Vol. 130, No. 7 July 1973

CUK-H03298-7-P024342

THE AMERICAN JOURNAL OF PSYCHIATRY

In this issue

Presidential Papers: 1973

This Month's Special Section

Problems of Childhood

7

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Thorazine® offers you a choice.

brand of **chlorpromazine**

18 Dosage Forms and Strengths

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.

Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.

Injection, 25 mg./ml.

Syrup, 10 mg./5 ml.

Suppositories, 25 mg. and 100 mg.

Concentrate, 30 mg./ml. and 100 mg./ml.



SK&F Smith Kline & French Laboratories, Philadelphia

THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

The American Journal of Psychiatry, formerly *The American Journal of Insanity*, is published monthly by the American Psychiatric Association. Editorial office: 1700 Eighteenth Street, N.W., Washington, D.C. 20009; telephone (202) 232-7878.

Subscriptions: U.S. $15.00 per year, Canada and South America $15.75, other foreign $18.00; single issues: $1.75 plus postage.

APA members should direct changes of address and communications about nonreceipt of the *Journal* to the Manpower Division, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

Communications from nonmember subscribers and all business communications should be directed to Mr. Robert J. Lowe, Publications Services Division, at the same address.

Advertising representatives: Steven K. Herlitz, Inc., 850 Third Avenue, New York, N.Y. 10022.

Type set by Bru-El Graphic, Inc., 5265 Port Royal Road, Springfield, Va. 22151.

Printed by Dartmouth Printing Co., 69 Lyme Road, Hanover, N.H. 03755.

Second class postage paid at Washington, D.C., and additional mailing offices.

Indexed in *Abstracts for Social Workers, Biological Abstracts, Chemical Abstracts, Cumulative Index to Nursing Literature, Excerpta Medica, Hospital Literature Index, Index Medicus, International Nursing Index, Nutrition Abstracts*, and *Psychological Abstracts*.

Copyright© 1973, the American Psychiatric Association.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers

Assistant Managing Editor
Amy E. Shaughnessy

Senior Assistant Editor
Linda A. Loy

Assistant Editors
Heidi A. Halter
Laura M. Little

Editorial Assistant
Katherine P. Olinick

Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.

LIBRARY
UNIVERSITY OF LOUISVILLE • C. U. •

£ 24,342

THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 7 July 1973

Presidential Papers: 1973

745 The Presidential Address: A Time for Action
Perry C. Talkington

748 Response to the Presidential Address
Alfred M. Freedman

750 Perry Clement Talkington, M.D., One Hundred and First President, 1972–1973
Henry W. Brosin

754 A Dimethyltryptamine-Forming Enzyme in Human Blood
Richard J. Wyatt, Juan M. Saavedra, and Julius Axelrod

761 Is Psychiatry as Establishment an Effective Force?
Milton H. Miller and James Auerbach

765 A Proposed "Dangerous Sex Offender" Law
Nathan T. Sidley and Francis J. Stolarz

769 Psychiatry with the Aborigines of West Malaysia
J. David Kinzie and J. Malcolm Bolton

774 Duodenal Ulcer Among Northwest Coastal Indian Women
James H. Shore and Dennis L. Stone

SPECIAL SECTION

Problems of Childhood

778 Children's Reactions to Temporary Loss of the Father
Frank E. Crumley and Ronald S. Blumenthal

783 The Life Course of Children with Schizophrenia
Lauretta Bender

786 Later Psychosocial Sequelae of Early Childhood Illness (Severe Croup)
J.J. Sigal, L. Chagoya, C. Villeneuve, and J. Mayerovitch

789 Psychiatric Consultations in a Children's Hospital
Edward P. Monnelly, Benjamin M. Ianzito, and Mark A. Stewart

791 Evidence for Polygenetic Inheritance in the Hyperactive Child Syndrome
James R. Morrison and Mark A. Stewart

792 Video Feedback in Treating Hyperkinetic Children: A Preliminary Report
Seymour Furman and Anne Feighner

796 Caffeine as a Substitute for Schedule II Stimulants in Hyperkinetic Children
Robert C. Schnackenberg

EDITORIAL

799 The Current Status of Child Psychiatry
Stuart M. Finch

BRIEF COMMUNICATIONS

801 Fluphenazine Enanthate and Fluphenazine Decanoate: A Comparison of Their Duration of Action and Motor Side Effects
H.M. van Praag and L.C.W. Dols

805 The Paraprofessional Teaches the Professional
John A. Talbott, Anita M. Ross, Alan F. Skerrett, Marion D. Curry, Stuart I. Marcus, Helen Theodorou, and Barbara J. Smith

808 Antagonism of Guanethidine by Chlorpromazine
David S. Janowsky, M. Khaled El-Yousef, John M. Davis, and William E. Fann

812 Effectiveness of Drug Education Programs for Secondary School Students
Sue C. Weaver and Forest S. Tennant, Jr.

814 Youth Psychopathology and Family Process Research
Leonard Hollander and Emil Karp

818 Clinical and Theoretical Consequences of the Misuse of Basic Behavior Therapy Concepts
David L. Braff

820 Manifestations of Concentration Camp Effects on the Second Generation
Harvey A. Barocas and Carol B. Barocas

IN MEMORIAM

822 Eugen Kahn, 1887–1973
Alex D. Pokorny

823 LETTERS TO THE EDITOR

827 BOOK REVIEWS

OFFICIAL ACTIONS

837 Highlights of the 126th Annual Meeting

839 The American Board of Psychiatry and Neurology

A64 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of
ticle: 60–100 words for regular articles, 40–60 words
Communications. The author may prepare the precis
ask that the *Journal* staff prepare it, in which case t
may make any necessary changes on the galley proofs.

References. References should be typed double-spa
separate sheet of paper, to be attached at the end of th
script. They should be arranged according to their
appearance in the text, where they should be indic
numbers in parentheses. Reference citations should
stricted to closely pertinent papers; a complete review
literature is rarely desirable, except in the case of review a
for which a special arrangement has been made with the Edi

References should be typed in accordance with the sty
shown below for books and journal articles; chapters in book
will be treated as journal articles with regard to capitalization
Up to three authors should be listed; one or more authors pa
the third will be designated "et al." Abbreviations of journa
names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxfo
University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephr
metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interacti
between monoamine oxidase inhibitors and foodstuffs. Br J Psy
chiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in
The Psychiatric Consultation. Edited by Mendel W, Solomon
New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and f
ures should be sufficiently clear that the meaning of the data
understandable without reference to the text. See recent issue
of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attache
the end of the manuscript. The data should be arranged
columns of like material read down, not across.

A complete set of figures, preferably in the form
prints, should accompany each of the two copies of
script. Most figures will be reduced to about 3¼
width, the column width of the *Journal*; all elements
should be prepared to withstand this reduction. Grap
be finished drawings not requiring further artwork.
are urged to engage the services of a professional in the
ration of figures. Authors may be required to meet the cos
any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for cc
rections after the paper has been scheduled for publicatio
prompt return (preferably within 48 hours of receipt) is nece
sary to ensure publication in the assigned month. If an autho
expects to be away from his office for a long period of time aft
he has received the acceptance letter, he should inform the *Jou
nal* office or arrange with a colleague to read the proofs. Au
thors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the gal
proofs submitted to authors for correction. Reprints are usua
mailed to authors about a month after publication of the artic
Requests from others to order reprints should be direct
to the Editor; inclusion of a letter of permission from the
senior author and a brief statement of the intended use of the
reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG
HERBERT KLEMMER
ALAN A. STONE
PERRY C. TALKINGTON

For two years: EWALD W. BUSSE
HENRIETTE R. KLEIN
MELVIN SABSHIN
JOHN R. SAUNDERS

For one year: ROBERT S. GARBER
JOHN E. NARDINI
IRVING PHILIPS
CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN

Constitution and By-Laws
WINFRED OVERHOLSER, JR.

Ethics

Membership
ALEXANDER LEVINE

Nominating
HOWARD P. ROME

Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN

Academic Education
HAROLD MCPHEETERS

Drug Abuse and Drug Education
PETER BOURNE

School Consultation
SHELDON D. GLASS

Conference on Family Life Education
ARNOLD M. KALLEN

Certification in Administrative Psychiatry
ARCHIE R. FOLEY

History

Medical Education
HAROLD I. KAPLAN

Psychiatry and Medical Practice
ROBERT A. SENESCU

Continuing Education
JAMES NAIMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG

Transcultural Psychiatry
RAMON PARRES

Joint Meeting in Australia 1975
ALFRED AUERBACK

Psychiatry and Foreign Affairs
WILLIAM D. DAVIDSON

Inter-American Council of Psychiatric Associations
HOWARD P. ROME

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER

Women in Psychiatry
NANCY A. ROESKE *and* ELISSA P. BENEDECK

Psychiatric Involvement in Family Planning
EUGENE B. BRODY

Psychosurgery
JOHN DONNELLY

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE

Drug Abuse
DANIEL X. FREEDMAN

Nomenclature and Statistics
HENRY BRILL

Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION

Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER

Lithium Therapy
IRVIN M. COHEN

Meditation
JAMES MORGAN

Effects of Television on Mental Health
JAMES H. RYAN

Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS

Psychiatry and the Law
STANLEY L. PORTNOW

Liaison with American Hospital Association
GERALD R. CLARK

Liaison with American College of Physicians
CHARLES P. NEUMANN

Psychiatric Nursing
WILLIAM E. STONE

Interprofessional Relations
WILLIAM W. ZELLER

Right to Treatment
BERNARD DIAMOND

Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN

Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON

Financing of Mental Health Care
JOHN M. COTTON

Federal Government Health Services
STEWART BAKER

Childhood and Adolescence
VIOLA BERNARD

Private Psychiatric Hospitals
JOHN H. HOUCK

Suicide Prevention
MATHEW ROSS

Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD

APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON

Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE

Professional Standards Review Organizations
FRANK SULLIVAN

COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT

Program
H. KEITH H. BRODIE

Film Review
EDWARD A. MASON

Closed-Circuit TV Presentations
MILTON BERGER

Arrangements
BENJAMIN JEFFRIES

Conventions
ALEXANDER SIMON

Scientific Exhibits
ROBERT FROELICH

Awards for Scientific Exhibits
SARA DUBO

Public Information
JAMES P. CATTELL

Member Insurance and Retirement Plans
CHESTER TRENT

Trustees of APA Retirement Plan
SANFORD L. BILLET

House
DANIEL JAFFE

Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON

Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.

Isaac Ray Award
JOHN K. TORRENS

Manfred S. Guttmacher Award
JONAS R. RAPPEPORT

Hofheimer Prize
DONALD F. KLEIN

McGavin Award
NORBERT B. ENZER

Vestermark Prize
BERTRAM S. BROWN

Grants and Awards
JACK WEINBERG

Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL

Black Psychiatrists
JAMES P. COMER

Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT

Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ

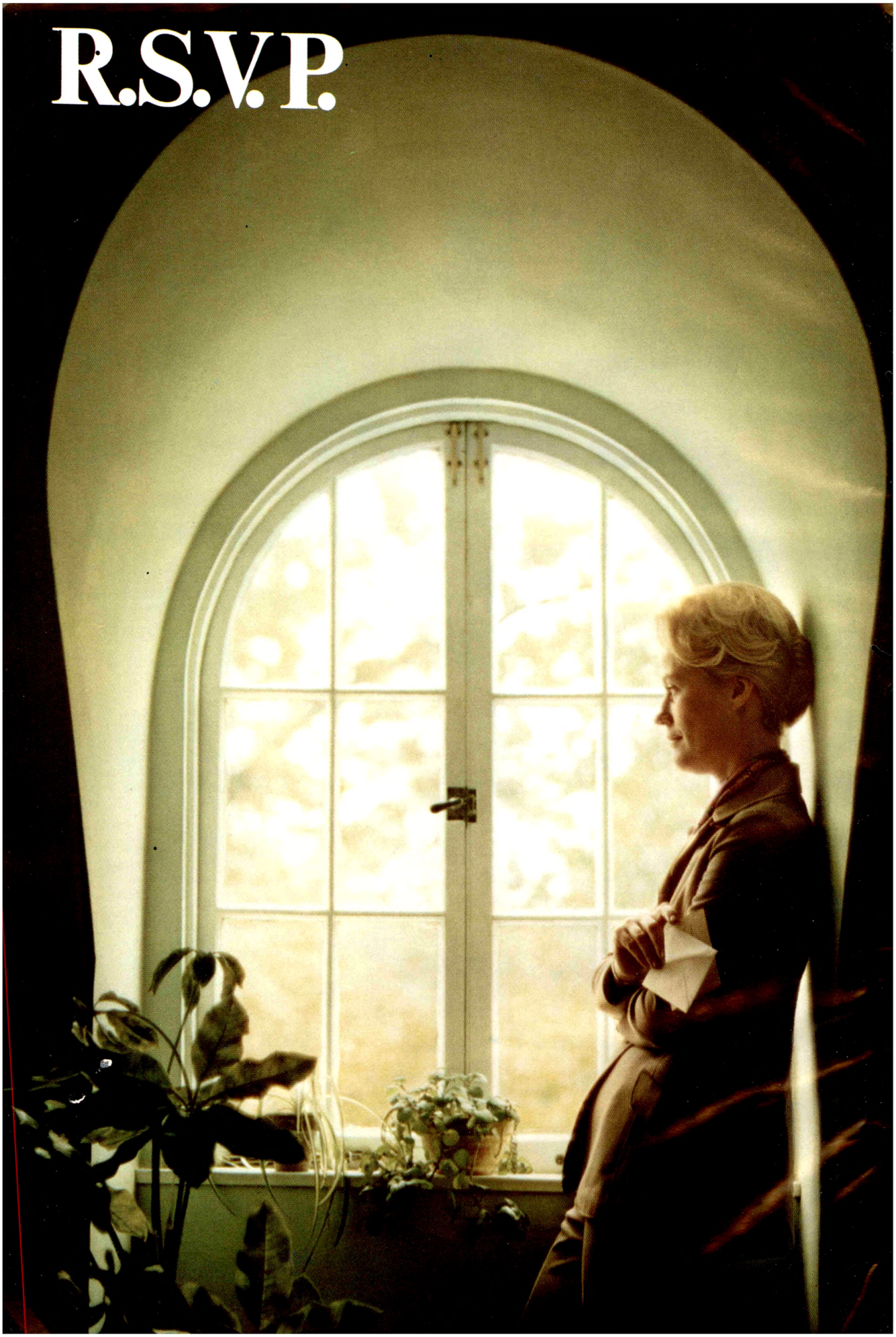
Indian Affairs
MORTON BEISER

Comprehensive Health Planning
ROBERT L. WILLIAMS

Third-Party Intervention in Community Crises
FRANK OCHBERG

Legislative Network
HAYDEN H. DONAHUE

R.S.V.P.



She just doesn't respond to things. No interest. No energy. Discouraged.

It may be mild depression. She needs help...and she needs it now.

Counsel and reassurance may suffice. But if you decide supportive medication is indicated, Ritalin can offer prompt benefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
(methylphenidate) helps the patient respond in mild depression*

Ritalin® hydrochloride ℂ
(methylphenidate hydrochloride)

TABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available.
Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported.
Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

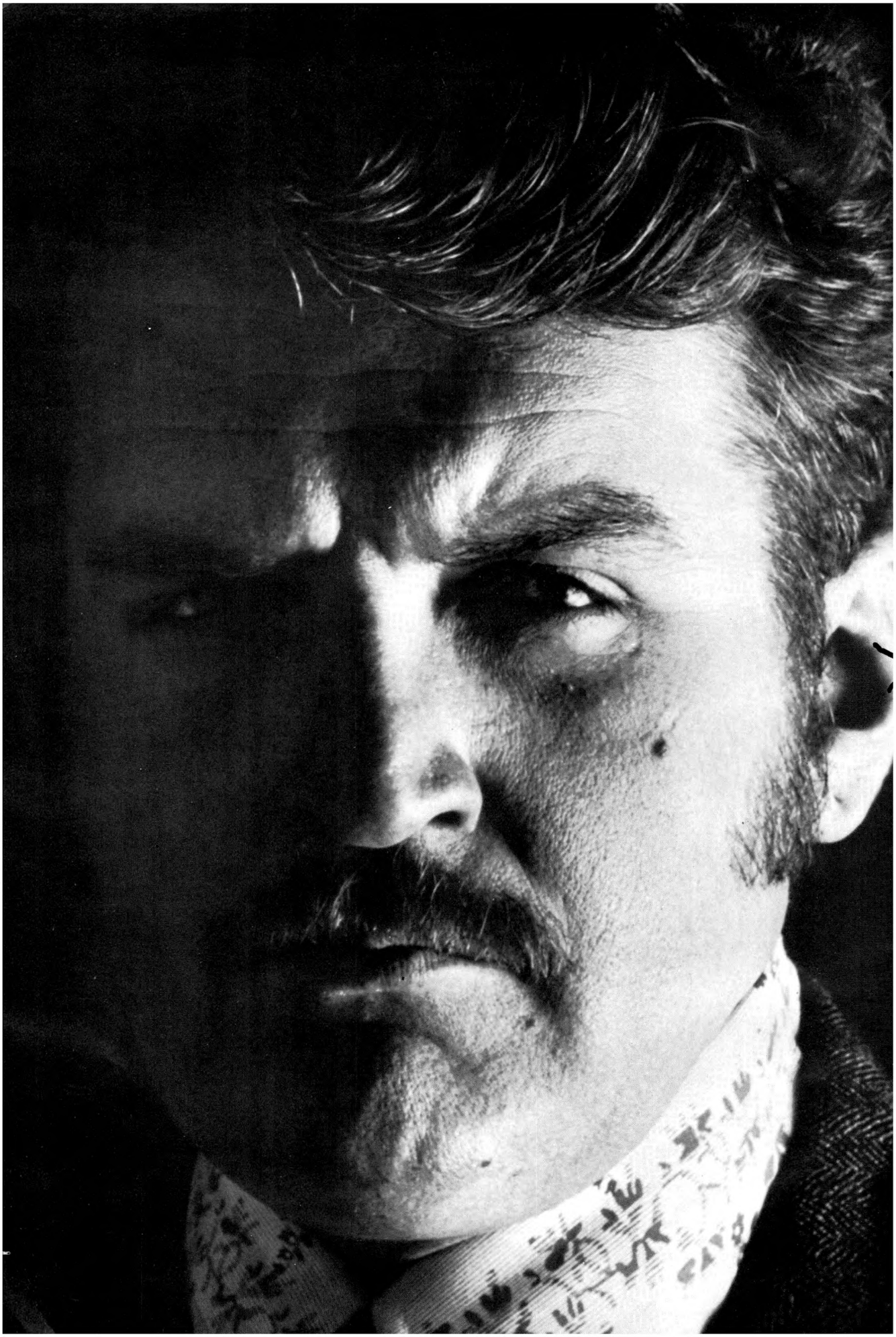
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4763-1 17

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

CIBA

A7



The hostile patient.

He vacillates from suspiciousness to rage.
His disorientation is apparent through
his erratic outbursts against imagined enemies.

His irrational behavior worries his family.
And hinders your treatment.
How do you reach him?

Very possibly, with QUIDE (piperacetazine).

Clinical studies of schizophrenic patients on a regimen of QUIDE have demonstrated moderate to excellent improvement in mental status and remission of hyperactive, combative behavior. Improvement in interpersonal relationships and adjustment to therapy were especially notable.

In clinical evaluation, although extrapyramidal reactions did occur, the low incidence of these reactions allowed for patient cooperation.

When Parkinsonism did occur, it was easily controlled by modification of dosage or, infrequently, the addition of an anti-Parkinson agent. Photosensitivity rarely occurred.

QUIDE (piperacetazine) . . . it may well be what some of your patients are waiting for.

Quide® tablets
piperacetazine

DOW **DOW PHARMACEUTICALS** The Dow Chemical Company Indianapolis, Indiana

See next page for complete prescribing information.

Quide® tablets
piperacetazine

DESCRIPTION: QUIDE (piperacetazine) is a piperidine derivative of phenothiazine.

Piperacetazine has the following chemical designation: 10- { 3-[4-(2-Hydroxyethyl)-piperidino]propyl } phenothiazin-2-yl Methyl Ketone.

ACTIONS: The exact mode of action of the phenothiazines is unclear, but drugs of this class produce changes at all levels of the central nervous system, as well as on multiple organ systems.

INDICATIONS: QUIDE is indicated for use in the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS: QUIDE is contraindicated in patients who are comatose or markedly depressed from any cause and in the presence of preexisting thrombocytopenia and other blood dyscrasias, bone marrow depression and in patients with significant liver disease. QUIDE is contraindicated in women who are or may become pregnant since animal reproductive studies adequate to establish safety during pregnancy have not been carried out. QUIDE is contraindicated in patients who have shown hypersensitivity to the drug. Cross sensitivity between phenothiazine derivatives may occur.

WARNING: Like other phenothiazines, QUIDE may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, patients should be cautioned accordingly. Concomitant use with alcohol should be avoided due to the potential additive effect. Patients with known suicidal tendencies should not be given QUIDE except under strict medical supervision.

Use in Children: The use of QUIDE in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Use with caution in persons who:

1. are receiving barbiturates or narcotics, because of additive effects on central nervous system depression. The dosage of the narcotic or barbiturate should be reduced when given concomitantly with QUIDE.
2. are receiving atropine or related drugs, because of additive anticholinergic effects.
3. have a history of epilepsy, because this drug may lower the convulsive threshold. Adequate anticonvulsant therapy must be maintained concomitantly.
4. are exposed to extreme heat or phosphorous insecticides.
5. have a history of peptic ulcer. Aggravation of preexisting ulcer has occurred.
6. have cardiovascular disease.
7. have respiratory impairment due to acute pulmonary infections or chronic respiratory disorders such as severe asthma or emphysema.

Keep in mind that the antiemetic effect may mask the toxicity of other drugs or obscure the diagnosis of such conditions as intestinal obstruction or brain tumor.

Any sign of blood dyscrasias requires immediate discontinuance of the drug and the institution of appropriate therapy.

The possibility of liver damage, pigmentary retinopathy, lenticular or corneal deposits, and development of irreversible dyskinesias should be kept in mind when patients are on prolonged therapy.

Abrupt Withdrawal: In general, phenothiazines do not produce psychic dependence, but gastritis, nausea and vomiting, dizziness and tremulousness have been reported following abrupt cessation of high-dose therapy. Reports suggest that these symptoms can be reduced if concomitant antiparkinson agents are continued for several weeks after the phenothiazine is withdrawn.

ADVERSE REACTIONS: Not all of the following adverse reactions have been reported with QUIDE (piperacetazine), but pharmacological similarities among various phenothiazine derivatives require that each be considered.

Note: Sudden Death has occasionally been reported in patients who have received phenothiazines. In some cases death was apparently due to cardiac arrest, in others the cause appeared to be asphyxia due to failure of the cough reflex. In some patients the cause could not be determined, nor could it be established that death was due to the phenothiazine.

Drowsiness: May occur particularly during the first or second week, after which it generally disappears. If troublesome, lower the dosage.

Jaundice: Incidence is low. When it occurs (usually between the second and fourth weeks of therapy) it is generally regarded as a sensitivity reaction. The clinical picture resembles infectious hepatitis with laboratory features of obstructive jaundice. It is usually reversible although chronic jaundice has been reported with phenothiazine therapy.

Hematological Disorders: Agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenia purpura and pancytopenia.

Agranulocytosis: Most cases have occurred between the fourth and tenth weeks of therapy. Patients should be watched closely during that period for the sudden appearance of sore throat or other signs of infection. If white blood count and differential show significant cellular depression, discontinue the drug and start appropriate therapy. A slightly lowered white count, however, is not in itself an indication to discontinue the drug.

Cardiovascular: Postural hypotension, tachycardia (especially following rapid increase in dosage), bradycardia, cardiac arrest, faintness and dizziness. Occasionally the hypotensive effect may produce a shock-like condition. In the event a vasoconstrictor is required, levarterenol and phenylephrine are the most suitable. Other pressor agents, including epinephrine, should not be used because a paradoxical further lowering of the blood pressure may ensue.

EKG changes, nonspecific, usually reversible, have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.

CNS Effects: Neuromuscular (extrapyramidal) Reactions: These are usually dose related and take three forms: (1) pseudoparkinsonism; (2) akathisia; and (3) dystonias (Dystonias include spasms of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, eyes rolled back, convulsions, trismus and swallowing difficulties). These resemble serious neurological disorders but usually subside within 48 hours. Management of the extrapyramidal symptoms, depending upon the type and severity, includes sedation, injectable diphenhydramine, and the use of antiparkinsonism agents.

Hyperreflexia has been reported in the newborn when a phenothiazine was used during pregnancy.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of the mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; anti-parkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Other CNS Effects: Cerebral edema. Abnormality of cerebral spinal fluid proteins. Convulsive seizures, particularly in patients with EEG abnormalities or a history of such disorders. Hyperpyrexia.

Adverse Behavioral Effects: Paradoxical exacerbation of psychotic symptoms.

Allergic Reactions: Urticaria, itching, erythema, photosensitivity (avoid undue exposure to the sun), eczema. Severe reactions include: exfoliative dermatitis (rare); contact dermatitis in nursing personnel administering the drug; asthma; laryngeal edema; angioneurotic edema; and anaphylactoid reactions.

Endocrine Disorders: Lactation and moderate breast engorgement in females and gynecomastia in males on large doses; changes in libido; false-positive pregnancy tests; amenorrhea; hyperglycemia, hypoglycemia, glycosuria.

Autonomic Reactions: Dry mouth, nasal congestion, constipation, adynamic ileus, myosis, mydriasis, urinary retention.

Special Considerations in Long-term Therapy: After prolonged administration of phenothiazines, pigmentation of the skin has occurred chiefly in the exposed areas, especially in females on large doses. Ocular changes consisting of deposition of fine particulate matter in the cornea and lens, progressing in more severe cases to star-shaped lenticular opacities; epithelial keratopathies; pigmentary retinopathy.

Other Adverse Reactions: Increases in appetite and weight; peripheral edema.

DOSAGE AND ADMINISTRATION: Dosage should be individualized, not only initially but during the course of therapy, and the minimal effective dose should always be employed. A starting dosage of 10 mg. two to four times daily is recommended for adults. The dose may be increased up to 160 mg. daily within a three to five day period. Should side effects occur, dosage should be reduced or discontinued as indicated. For maintenance therapy, up to 160 mg. daily in divided doses may be given.

OVERDOSAGE WITH PHENOTHIAZINES:

Manifestations: One of three clinical pictures may be seen.

1. Extreme somnolence; patient can usually be roused with prodding, but if permitted will fall asleep. General condition is usually satisfactory. The skin, though pale, is warm and dry. Slight blood pressure, respiratory and pulse changes may occur but are not problems.
2. Mild to moderate drop in blood pressure (patient may be conscious or unconscious). Skin is markedly gray but warm and dry. Nail beds are pink. Respiration is slow and regular. Pulse is strong but rate slightly increased.
3. Severe hypotension, possibly accompanied by weakness, cyanosis, perspiration, rapid thready pulse and respiratory depression.

Treatment: Is essentially symptomatic and supportive. Early gastric lavage and intestinal purges may help. Centrally acting emetics may not help because of the possible antiemetic effect of QUIDE. Give hot tea or coffee. Severe hypotension usually responds to measures described under hypotensive effects (see ADVERSE REACTIONS: *Cardiovascular).* Additional measures include pressure bandages to lower limbs, oxygen and I.V. fluids.

Avoid stimulants that may cause convulsions (e.g., picrotoxin and pentylenetetrazol).

Limited experience with dialysis indicates that it is not helpful.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED:

QUIDE (piperacetazine) Tablets—10 mg. (orange)—bottles of 100 (NDC 183-52-2), and bottles of 1000 (NDC 183-52-4).

QUIDE (piperacetazine) Tablets—25 mg. (yellow)—bottles of 100 (NDC 183-53-2), and bottles of 1000 (NDC 183-53-4).

Note: Dispense only in light-resistant containers; the coatings on these tablets contain light-sensitive colors.

January 1973

DOW PHARMACEUTICALS The Dow Chemical Company Indianapolis, Indiana

P 24,342

PUT THESE TEXTS TO WORK FOR YOU

☐ **ISSUES AND TRENDS IN BEHAVIOR THERAPY** *edited by* **Henry E. Adams,** *Univ. of Georgia and* **Irving P. Unikel,** *Veterans Administration Hospital, Atlanta, Georgia. (10 Contributors).* An evaluation of selected current and significant issues and trends in behavior therapy. Part I is concerned with issues and theoretical developments. Part II gives evidence of major trends in behavior therapy. The widening scope of application of behavioral treatment techniques, and trends toward treatment in the natural environment and use of procedures which employ people who are not highly-trained professionals are discussed. *'73, about 224 pp., 38 il., 14 tables, cloth, paper*

☐ **FAMILY ROOTS OF SCHOOL LEARNING AND BEHAVIOR DISORDERS** *edited by* **Robert Friedman,** *Univ. of Southern California School of Medicine, Los Angeles. (12 Contributors).* Provides educators and mental health clinicians for the first time with a comprehensive overview of the family aspect of school-related problems. The chapters combine theory and practice in dealing with learning and behavior disorders in preschool thru high school. Parental values and attitudes, parent-child relationships, and family interactional systems are related to cultural diversity and social change. Much new material is included in the specific diagnostic procedures and school guidance and clinical treatment approaches that are described in detail. *'73, 360 pp., cloth $14.75, paper $9.50*

☐ **MENTAL DEVELOPMENT EVALUATION OF THE PEDIATRIC PATIENT** *by* **Lawrence C. Hartlage** *and* **David G. Lucas,** *both of Indiana Univ. Medical Center, Indianapolis.* Designed for use by the busy physician, this text contains comprehensive screening items for quickly assessing a given child's level of mental development in cognitive, perceptual-motor language and academic areas, ages two through nine, and provides guidelines for the use of ancillary personnel for much of the screening process. The book presents a series of mental development expectancies for given ages against which the physician can compare children under consideration. *'73, 92 pp., 36 il., $6.50*

☐ **THE MODIFICATION OF LANGUAGE BEHAVIOR** *edited by* **Benjamin B. Lahey,** *Florida Technological Univ., Orlando. (12 Contributors)* Disorders that had previously been resistant to treatment, or that had required complicated, long-term procedures, have recently been shown to be amenable to the simple and efficient techniques of behavior modification. Although most of these papers are by psychologists, the techniques are directly applicable to communication specialists in speech therapy, educational psychology, child psychiatry and pediatrics. There has been a recent growth of interest in this field. *'73, 352 pp., 73 il., 28 tables, cloth $11.95, paper $6.95*

☐ **MAN FOR MAN: A Multidisciplinary Workshop on Affecting Man's Social and Psychological Nature Through Community Action** *edited by* **John L. Carleton,** *Santa Barbara Psychiatric Medical Group, and* **Ursula Mahlendorf,** *Univ. of California, Santa Barbara. (18 Contributors)* '73, 384 pp., $10.95

☐ **CRISIS CENTER HOTLINE: A Guidebook to Beginning and Operating** *edited by* **Ursula Delworth, Edward H. Rudow** *and* **Janet Taub,** *all of Colorado State Univ., Fort Collins. Foreword by* **Weston Morrill.** *(12 Contributors)* '72, 160 pp., $9.75

☐ **THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS** *edited by* **Max Hammer,** *Univ. of Maine, Orono. (10 Contributors)* '72, 464 pp., $16.75

☐ **CLINICAL USE OF PSYCHOTHERAPEAUTIC DRUGS** *by* **Leo E. Hollister,** *Stanford Univ. School of Medicine, Palo Alto, California.* '73, 192 pp., 11 il., 13 tables, $6.95

☐ **THE PSYCHOLOGY OF OBESITY: Dynamics and Treatment** *edited by* **Norman Kiell,** *Brooklyn College, New York.* '73, 480 pp. (6⅞ x 9⅝), 41 tables, $13.95

☐ **A MILIEU THERAPY PROGRAM FOR BEHAVIORALLY DISTURBED CHILDREN** *by* **Marjorie McQueen Monkman,** *Univ. of Illinois, Urbana.* '72, 312 pp., 21 il., 3 tables, $14.50

☐ **TECHNIQUES FOR BEHAVIOR CHANGE: Applications of Adlerian Theory (2nd Ptg.)** *compiled and edited by* **Arthur G. Nikelly,** *Univ. of Illinois Health Center, Urbana. Foreword by* **Alexandra Adler.** *Epilogue by* **Rudolf Dreikurs.** *(28 Contributors)* '72, 244 pp., $10.50

☐ **COUNSELING PARENTS OF THE EMOTIONALLY DISTURBED CHILD** *compiled and edited by* **Robert L. Noland,** *Univ. of Dayton, Ohio. (45 Contributors)* '72, 452 pp., 7 il., $11.50

☐ **THE ADOLESCENT GAP: Research Findings on Drug Using and Non-Drug Using Teens** *by* **Edward M. Scott,** *Univ. of Oregon Medical School, Portland. Foreword by* **Rev. Theodore M. Hesburgh.** *Chapter by* **Chuck Paulus.** '72, 160 pp., 1 il., $6.95

☐ **ON THE PSYCHOLOGY OF WOMEN: A Survey of Empirical Studies (2nd Ptg.)** *by* **Julia A. Sherman,** Madison, Wisconsin. '73, 320 pp., cloth $10.75, paper $6.75

CHARLES C THOMAS • PUBLISHER 301-327 East Lawrence Avenue **SPRINGFIELD • ILLINOIS • 62717**



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

torrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitivity; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance — vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

Anxiety Amelioration — in terms of motor, affective, autonomic and verbal phenomenon.

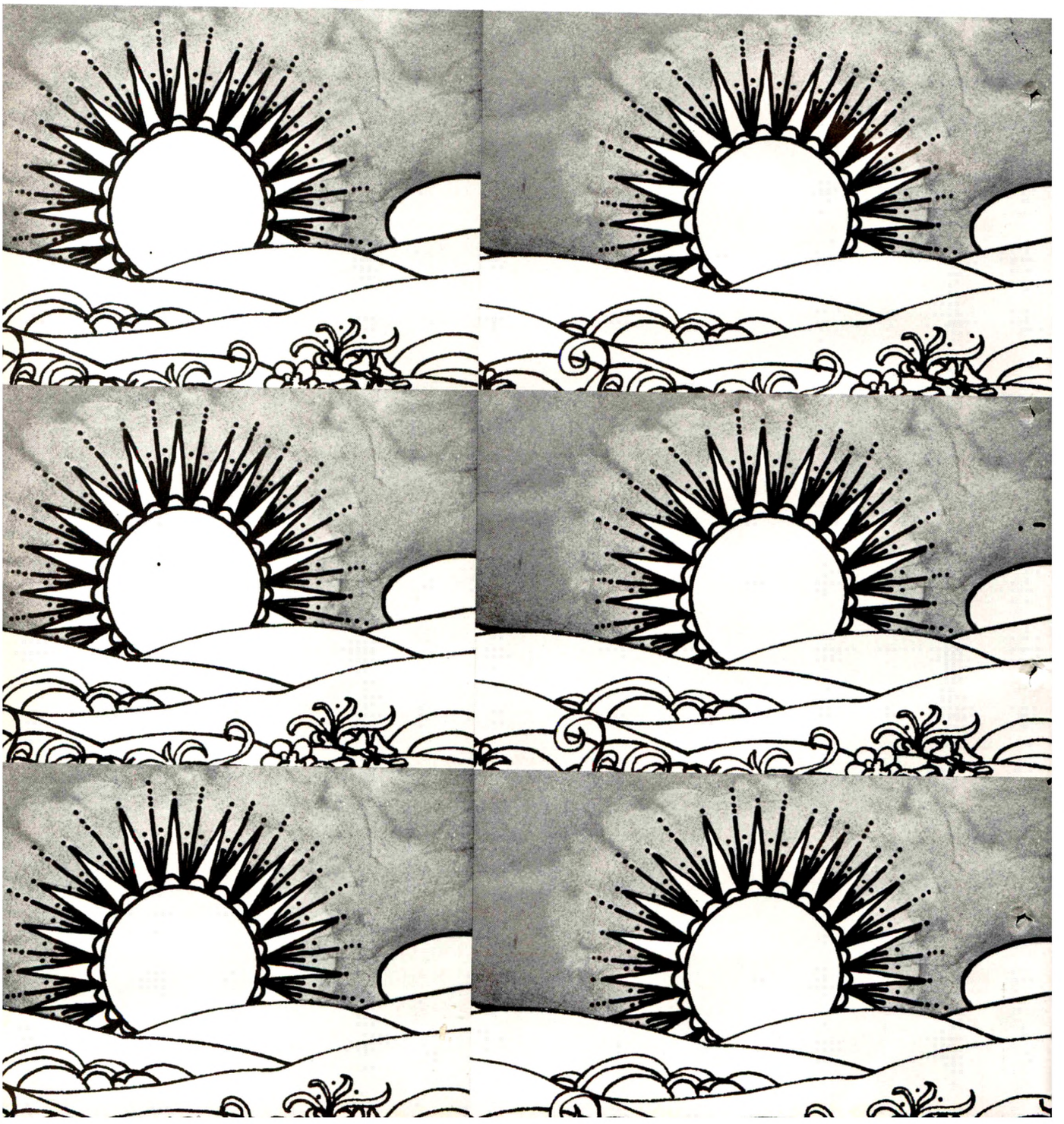
1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.

The new-day constant for drug-induced parkinsonism:



P 24,342

PUT THESE TEXTS TO WORK FOR YOU

☐ **ISSUES AND TRENDS IN BEHAVIOR THERAPY** *edited by* **Henry E. Adams,** *Univ. of Georgia and* **Irving P. Unikel,** *Veterans Administration Hospital, Atlanta, Georgia. (10 Contributors).* An evaluation of selected current and significant issues and trends in behavior therapy. Part I is concerned with issues and theoretical developments. Part II gives evidence of major trends in behavior therapy. The widening scope of application of behavioral treatment techniques, and trends toward treatment in the natural environment and use of procedures which employ people who are not highly-trained professionals are discussed. *'73, about 224 pp., 38 il., 14 tables, cloth, paper*

☐ **FAMILY ROOTS OF SCHOOL LEARNING AND BEHAVIOR DISORDERS** *edited by* **Robert Friedman,** *Univ. of Southern California School of Medicine, Los Angeles. (12 Contributors).* Provides educators and mental health clinicians for the first time with a comprehensive overview of the family aspect of school-related problems. The chapters combine theory and practice in dealing with learning and behavior disorders in preschool thru high school. Parental values and attitudes, parent-child relationships, and family interactional systems are related to cultural diversity and social change. Much new material is included in the specific diagnostic procedures and school guidance and clinical treatment approaches that are described in detail. *'73, 360 pp., cloth $14.75, paper $9.50*

☐ **MENTAL DEVELOPMENT EVALUATION OF THE PEDIATRIC PATIENT** *by* **Lawrence C. Hartlage** *and* **David G. Lucas,** *both of Indiana Univ. Medical Center, Indianapolis.* Designed for use by the busy physician, this text contains comprehensive screening items for quickly assessing a given child's level of mental development in cognitive, perceptual-motor language and academic areas, ages two through nine, and provides guidelines for the use of ancillary personnel for much of the screening process. The book presents a series of mental development expectancies for given ages against which the physician can compare children under consideration. *'73, 92 pp., 36 il., $6.50*

☐ **THE MODIFICATION OF LANGUAGE BEHAVIOR** *edited by* **Benjamin B. Lahey,** *Florida Technological Univ., Orlando. (12 Contributors)* Disorders that had previously been resistant to treatment, or that had required complicated, long-term procedures, have recently been shown to be amenable to the simple and efficient techniques of behavior modification. Although most of these papers are by psychologists, the techniques are directly applicable to communication specialists in speech therapy, educational psychology, child psychiatry and pediatrics. There has been a recent growth of interest in this field. *'73, 352 pp., 73 il., 28 tables, cloth $11.95, paper $6.95*

☐ **MAN FOR MAN: A Multidisciplinary Workshop on Affecting Man's Social and Psychological Nature Through Community Action** *edited by* **John L. Carleton,** *Santa Barbara Psychiatric Medical Group, and* **Ursula Mahlendorf,** *Univ. of California, Santa Barbara. (18 Contributors)* '73, 384 pp., $10.95

☐ **CRISIS CENTER HOTLINE: A Guidebook to Beginning and Operating** *edited by* **Ursula Delworth, Edward H. Rudow** *and* **Janet Taub,** *all of Colorado State Univ., Fort Collins. Foreword by* **Weston Morrill.** *(12 Contributors)* '72, 160 pp., $9.75

☐ **THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS** *edited by* **Max Hammer,** *Univ. of Maine, Orono. (10 Contributors)* '72, 464 pp., $16.75

☐ **CLINICAL USE OF PSYCHOTHERAPEAUTIC DRUGS** *by* **Leo E. Hollister,** *Stanford Univ. School of Medicine, Palo Alto, California.* '73, 192 pp., 11 il., 13 tables, $6.95

☐ **THE PSYCHOLOGY OF OBESITY: Dynamics and Treatment** *edited by* **Norman Kiell,** *Brooklyn College, New York.* '73, 480 pp. ($6\frac{3}{8}$ x $9\frac{5}{8}$), 41 tables, $13.95

☐ **A MILIEU THERAPY PROGRAM FOR BEHAVIORALLY DISTURBED CHILDREN** *by* **Marjorie McQueen Monkman,** *Univ. of Illinois, Urbana.* '72, 312 pp., 21 il., 3 tables, $14.50

☐ **TECHNIQUES FOR BEHAVIOR CHANGE: Applications of Adlerian Theory (2nd Ptg.)** *compiled and edited by* **Arthur G. Nikelly,** *Univ. of Illinois Health Center, Urbana. Foreword by* **Alexandra Adler.** *Epilogue by* **Rudolf Dreikurs.** *(28 Contributors)* '72, 244 pp., $10.50

☐ **COUNSELING PARENTS OF THE EMOTIONALLY DISTURBED CHILD** *compiled and edited by* **Robert L. Noland,** *Univ. of Dayton, Ohio. (45 Contributors)* '72, 452 pp., 7 il., $11.50

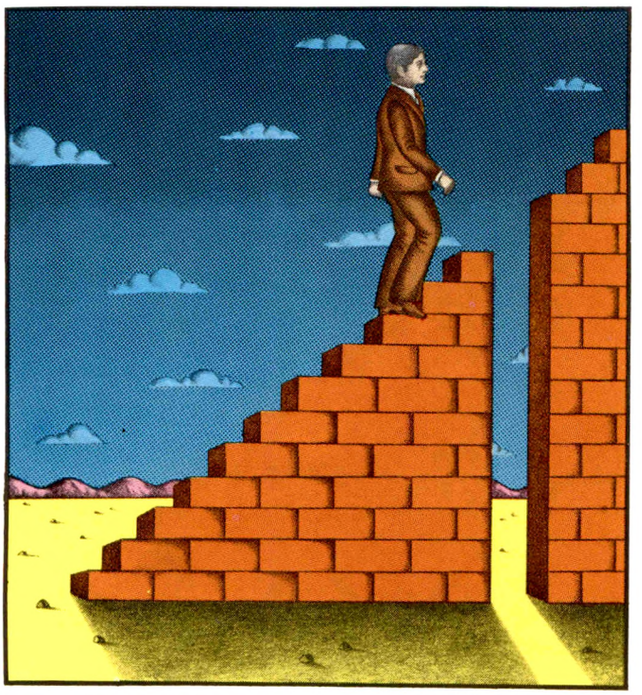
☐ **THE ADOLESCENT GAP: Research Findings on Drug Using and Non-Drug Using Teens** *by* **Edward M. Scott,** *Univ. of Oregon Medical School, Portland. Foreword by* **Rev. Theodore M. Hesburgh.** *Chapter by* **Chuck Paulus.** '72, 160 pp., 1 il., $6.95

☐ **ON THE PSYCHOLOGY OF WOMEN: A Survey of Empirical Studies (2nd Ptg.)** *by* **Julia A. Sherman,** Madison, Wisconsin. '73, 320 pp., cloth $10.75, paper $6.75

CHARLES C THOMAS • PUBLISHER 301-327 East Lawrence Avenue **SPRINGFIELD • ILLINOIS • 62717**

The psychoneurotic patient's prognosis may be good...

As a group, psychoneurotic patients tend to respond positively to psychotherapy. Follow-up studies indicate that up to two-thirds of treated patients may show significant and often sustained improvement.



In individual cases, the prognosis appears particularly favorable for the psychoneurotic who has had a good premorbid personality structure and a record of reasonably good interpersonal competence. As might be expected, patients judged to be "attractive" candidates for therapy often tend to derive greater benefits from therapeutic intervention than those considered "unattractive."

The global assessment of "attractiveness" is influenced by such factors as youthfulness, intelligence, ability to relate and good occupational history.

But excessive anxiety can block recovery...

Anxiety is the hallmark of psychoneurotic states. In excess it may not alter the patient's "prognostic rating," but it can slow therapeutic progress—sometimes to a marked extent. At the outset of therapy, for instance, severe or persistent anxiety can be particularly

obstructive, sometimes hampering for long periods the patient's ability to participate in a productive psychotherapeutic relationship. At later stages, intense anxiety may impair the patient's receptivity to further probing and block his attempts to retrieve and express pertinent material.

When the patient's disabling anxiety continues to impede therapeutic progress, management of his condition may often be significantly facilitated by adjunctive Librium (chlordiazepoxide HCl).

Librium generally relieves excessive anxiety without unduly impairing mental acuity or ability to perform. As with all CNS-acting drugs, however, patients should be cautioned against hazardous occupations requiring complete mental alertness. (See Warnings section in summary of prescribing information.) When the patient's anxiety has been reduced to appropriate levels, Librium should, of course, be discontinued.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

To relieve obstructive anxiety consider Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules
Up to 100 mg daily for severe anxiety

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

NEUROLOGICAL STIMULATOR



"Your machine has made all my others obsolete"

(Leading N.Y. psychiatrist)

- Safe Battery Operation
- Full Range of Control for Frequency & Pulse Widths.
- Constant Current Output Mode
- Lightweight—Portable (3 pounds)
- Reliable Solid State Circuits
- Use It For Your TCET (Electrosleep Therapy)
- Electrodes / Headbands Available
- Fully Guaranteed
- Lowest Cost – Model GI-1007-1 Only $235.

Send or phone for full details: **(805) 687-0483**

GENERAL INDUSTRIES medical products division
969 Barcelona Drive, Santa Barbara, California 93105

The Country Place

LITCHFIELD, CONNECTICUT



THE COUNTRY PLACE is a residential community for the emotionally disturbed adult who has more insight than he can use, who knows how he should act but withdraws from action.

THE COUNTRY PLACE offers
a home where he is understood
a work place where he can cope with the demands
a community where he can find social identity

THE COUNTRY PLACE
provides team work in socially useful projects
self help through interaction in groups
exploration of existent reality

THE COUNTRY PLACE maintains a well-trained professional staff for individual and group therapy psychodrama, art, dance and music therapy, as well as sports and games

WEEK END WORKSHOPS for professionals interested in studying our method of helping the disturbed person in creating a new identity

Address inquiries to:

RENEE NELL, ED.D.
THE COUNTRY PLACE
Litchfield, Conn. 06759
Telephone: (203) 567-8763

The

August 1973

Issue

of the

American

Journal

of

Psychiatry

Features

a

Special Section on

"Aspects

of

Hospitalization"

Are you actively interested in the clinical evaluation of:

PSYCHOSOMATIC DISFUNCTION, PHOBIAS, **STRESS RELATED DISORDERS**, **INSOMNIA**, RELAXATION TRAINING, TENSION HEADACHES, **BEHAVIOR MODIFICATION**, **MUSCLE REHABILITATION**, SYSTEMATIC DESENSITIZATION, **MIGRAINE HEADACHES**, CIRCULATORY DISORDERS, RUMINATIVE DEPRESSION, **ANXIETY CONTROL**.

Recent studies indicate Biofeedback, as a treatment modality, may be of great value to clinical investigators in these areas.

We would like to send you information regarding the latest Biofeedback Instrumentation and how it may be useful to you in your work.

Write:
CYBORG CORPORATION
Dept. P
Faulkner Street
North Billerica, Mass. 01862
(617) 667-3826

Please specify your particular interests so that we may forward appropriate information.

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

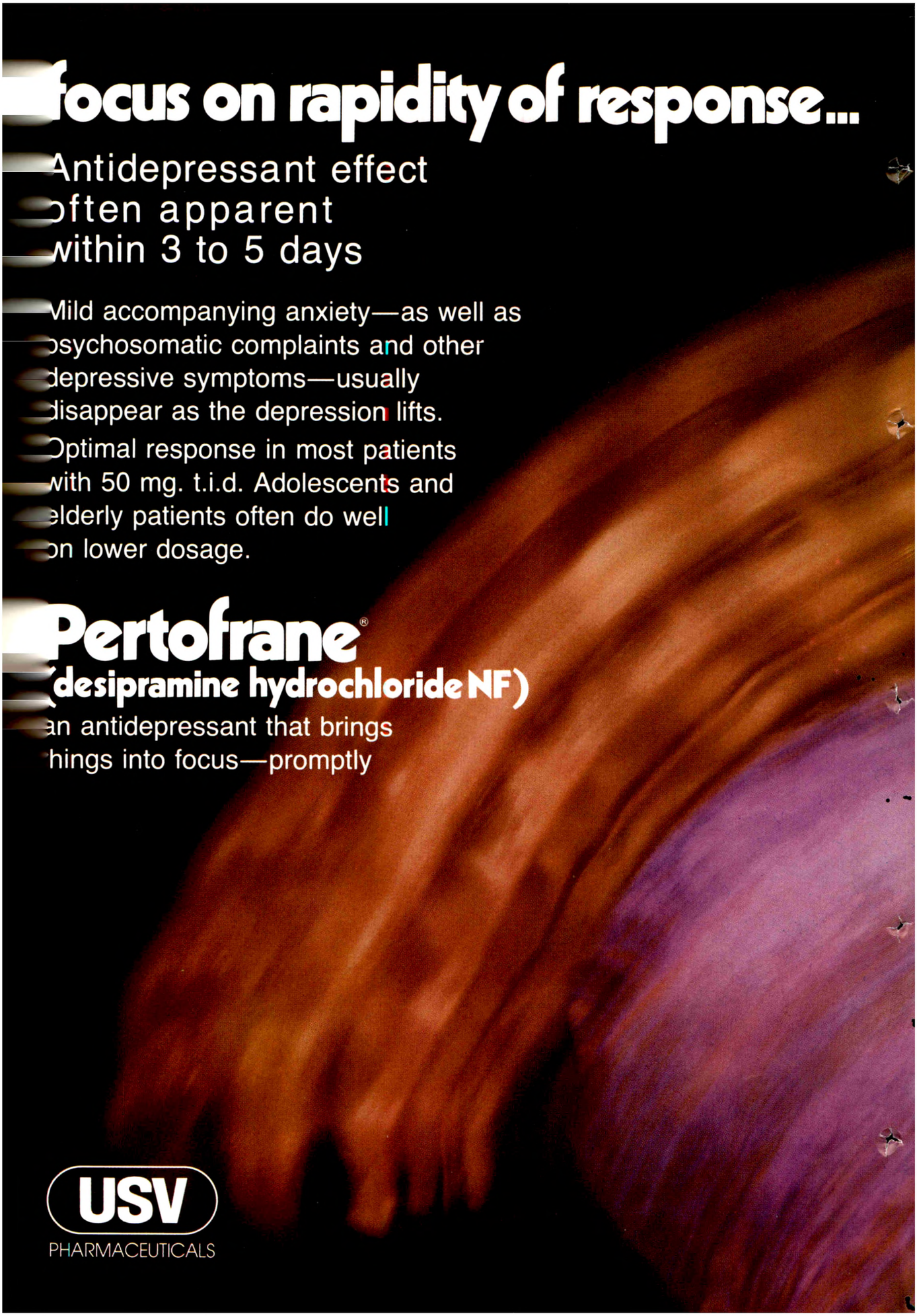
Summit, N. J. 07901 **(201) 277-0143**

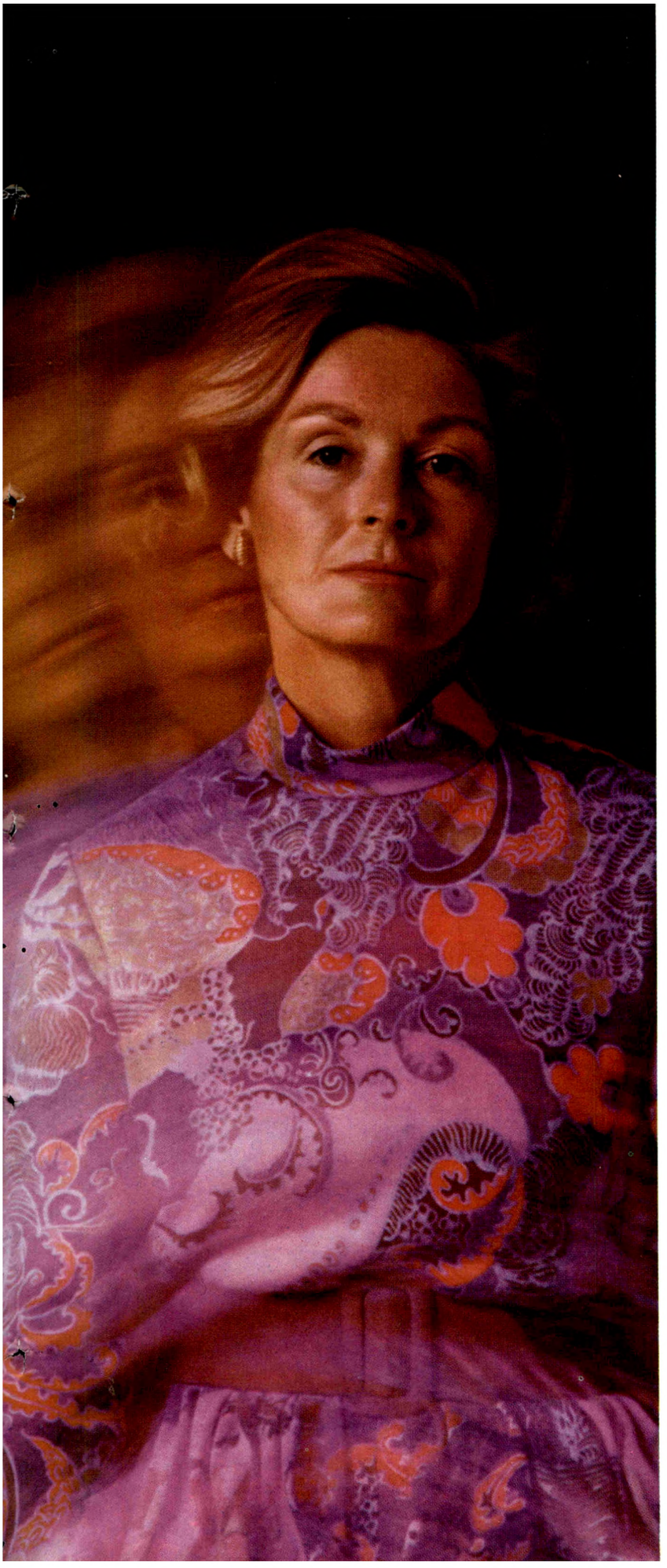
An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director
OSCAR ROZETT, M.D., Medical Administrator
GRANVILLE L. JONES, M.D., Director of Research
FELIX A. UCKO, M.D., Chief, Adolescent Program
MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator


focus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS

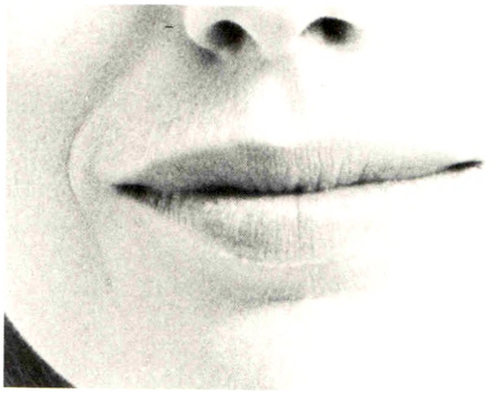


Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises o severe convulsive seizures may occur with such combinations potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroi patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG pattern epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipatio and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function test occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urina frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 m daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

The TRIAVIL® Potential in the management of moderate to severe anxiety with depression

When time and talk are not enough...
The therapist is the primary catalyst for change in the psychotherapeutic relationship. However, when patients suffer from moderate to severe anxiety with depression, there are situations when TRIAVIL can often be a useful adjunct.

...TRIAVIL may help
There are three important benefits you may expect when TRIAVIL is part of the treatment program: (1) When symptoms of moderate to severe anxiety or agitation with depression are relieved, the patient may become more accessible and cooperative. (2) As somatic manifestations are controlled, attention may be focused on underlying causative factors. (3) Symptomatic relief may enable the patient to function more effectively in his daily life while your work with the patient progresses.

Since it is simpler to remember to take one tablet rather than several (particularly in multiple daily doses), your patients on TRIAVIL will be more likely to take proper doses of the medication. And, of course, economy is an added factor in therapy with TRIAVIL.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

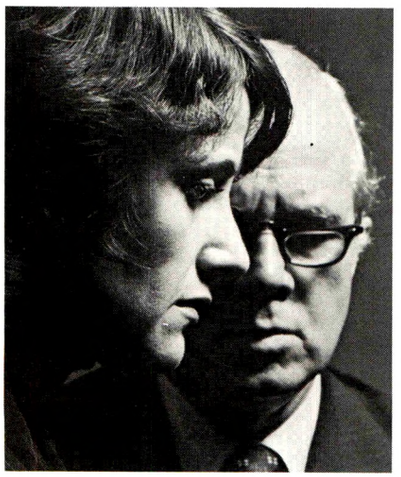
MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression

TRIAVIL® (containing perphenazine and amitriptyline HCl)
an antidepressant tranquilizer

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression



TRIAVIL® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practice when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; pregnancy; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction. Not recommended in children.

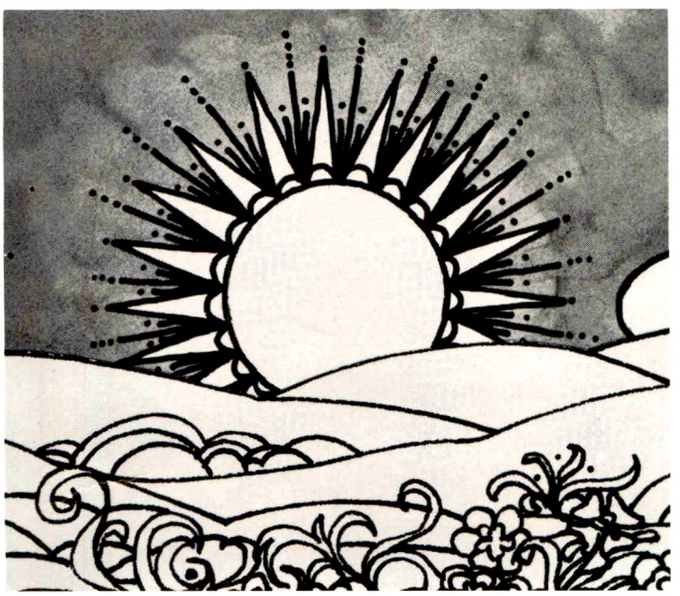
WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, narrow-angle glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage.
The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.
A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.
If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine.
Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant drug. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL has seemed to reduce the likelihood of this effect.
Supervise closely and carefully adjust dosage when given with anticholinergic agents and sympathomimetic drugs.
The drug may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards of therapy. Such treatment should be limited to patients for whom it is essential.
Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crises, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reaction); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galac-

ARTANE®
TRIHEXYPHENIDYL HCl

Non-cumulative action makes each day of therapy a new day



That's why ARTANE is ideally suited for the patient on long-term phenothiazine therapy. In economical tablets or SEQUELS Sustained Release Capsules*, it offers you *more* than the rapid reversal of extrapyramidal symptoms.

Usually there is no drug buildup to cause undue toxicity in prolonged therapy. Minimal atropine-like side effects. Accurate dosage titration in adjunctive use. And, to minimize missed doses and anxiety in outpatient therapy— one-dose *all-day* control or prevention with SEQUELS.*

For hospitalized or ambulatory patients, ARTANE has the "constant" they need. Effective *non-cumulative* action.

Tablets—2 mg, 5 mg; Elixir†—2 mg/5 cc or SEQUELS® Sustained Release Capsules—5 mg.

Tablets and Elixir Indications: FDA has evaluated this drug as Effective as an adjunct in the therapy of the indications listed below under SEQUELS.

***INDICATIONS FOR ARTANE SEQUELS:**
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms of parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine and phenothiazines.

WARNING:
Patients to be treated should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache.

†Lime-mint flavored, with 0.08% methylparaben, 0.02% propylparaben, and 5% alcohol as preservatives.

*This drug in sustained release form has been evaluated as probably effective. See Brief Summary.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

716-3

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

In severe anxiety

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

Please see important information on page after next.

ANTABUSE® (DISULFIRAM)

a strong deterrent for the alcoholic who doesn't want to drink



BRIEF SUMMARY *(For full prescribing information, see package circular.)*

ANTABUSE® Brand of disulfiram
In Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, *e.g.* cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

WARNINGS

ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hapatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, it should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

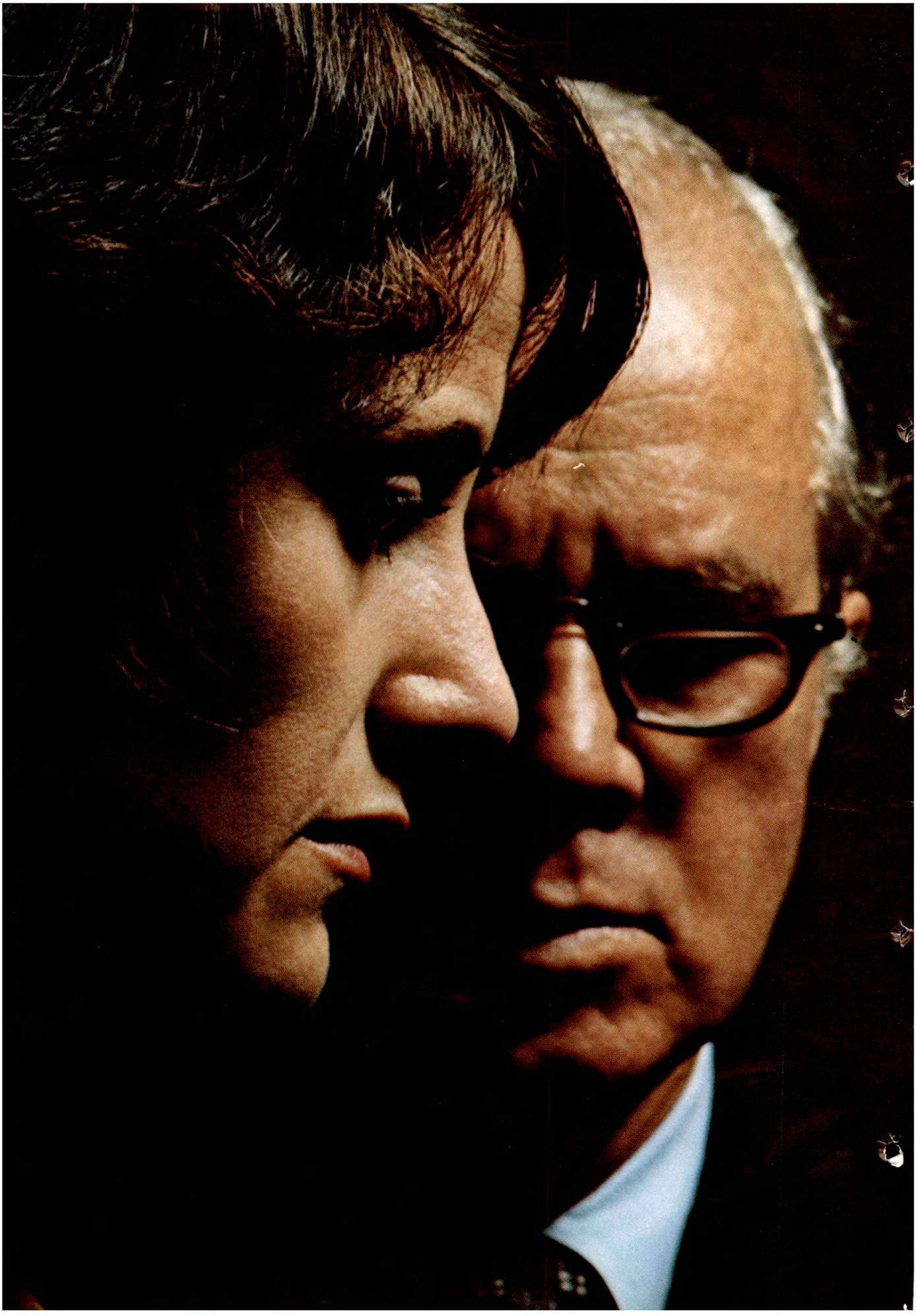
After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokaliemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017

7306



The hostile patient.

He vacillates from suspiciousness to rage.
His disorientation is apparent through
his erratic outbursts against imagined enemies.

His irrational behavior worries his family.
And hinders your treatment.
How do you reach him?

Very possibly, with QUIDE (piperacetazine).

Clinical studies of schizophrenic patients on a regimen of QUIDE have demonstrated moderate to excellent improvement in mental status and remission of hyperactive, combative behavior. Improvement in interpersonal relationships and adjustment to therapy were especially notable.

In clinical evaluation, although extrapyramidal reactions did occur, the low incidence of these reactions allowed for patient cooperation.

When Parkinsonism did occur, it was easily controlled by modification of dosage or, infrequently, the addition of an anti-Parkinson agent. Photosensitivity rarely occurred.

QUIDE (piperacetazine) . . . it may well be what some of your patients are waiting for.

Quide® tablets
piperacetazine

DOW **DOW PHARMACEUTICALS** The Dow Chemical Company Indianapolis, Indiana

See next page for complete prescribing information.

Quide® tablets
piperacetazine

DESCRIPTION: QUIDE (piperacetazine) is a piperidine derivative of phenothiazine.

Piperacetazine has the following chemical designation: 10- { 3-[4-(2-Hydroxyethyl)-piperidino]propyl } phenothiazin-2-yl Methyl Ketone.

ACTIONS: The exact mode of action of the phenothiazines is unclear, but drugs of this class produce changes at all levels of the central nervous system, as well as on multiple organ systems.

INDICATIONS: QUIDE is indicated for use in the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS: QUIDE is contraindicated in patients who are comatose or markedly depressed from any cause and in the presence of preexisting thrombocytopenia and other blood dyscrasias, bone marrow depression and in patients with significant liver disease. QUIDE is contraindicated in women who are or may become pregnant since animal reproductive studies adequate to establish safety during pregnancy have not been carried out. QUIDE is contraindicated in patients who have shown hypersensitivity to the drug. Cross sensitivity between phenothiazine derivatives may occur.

WARNING: Like other phenothiazines, QUIDE may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, patients should be cautioned accordingly. Concomitant use with alcohol should be avoided due to the potential additive effect. Patients with known suicidal tendencies should not be given QUIDE except under strict medical supervision.

Use in Children: The use of QUIDE in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Use with caution in persons who:

1. are receiving barbiturates or narcotics, because of additive effects on central nervous system depression. The dosage of the narcotic or barbiturate should be reduced when given concomitantly with QUIDE.
2. are receiving atropine or related drugs, because of additive anticholinergic effects.
3. have a history of epilepsy, because this drug may lower the convulsive threshold. Adequate anticonvulsant therapy must be maintained concomitantly.
4. are exposed to extreme heat or phosphorous insecticides.
5. have a history of peptic ulcer. Aggravation of preexisting ulcer has occurred.
6. have cardiovascular disease.
7. have respiratory impairment due to acute pulmonary infections or chronic respiratory disorders such as severe asthma or emphysema.

Keep in mind that the antiemetic effect may mask the toxicity of other drugs or obscure the diagnosis of such conditions as intestinal obstruction or brain tumor.

Any sign of blood dyscrasias requires immediate discontinuance of the drug and the institution of appropriate therapy.

The possibility of liver damage, pigmentary retinopathy, lenticular or corneal deposits, and development of irreversible dyskinesias should be kept in mind when patients are on prolonged therapy.

Abrupt Withdrawal: In general, phenothiazines do not produce psychic dependence, but gastritis, nausea and vomiting, dizziness and tremulousness have been reported following abrupt cessation of high-dose therapy. Reports suggest that these symptoms can be reduced if concomitant antiparkinson agents are continued for several weeks after the phenothiazine is withdrawn.

ADVERSE REACTIONS: Not all of the following adverse reactions have been reported with QUIDE (piperacetazine), but pharmacological similarities among various phenothiazine derivatives require that each be considered.

Note: Sudden Death has occasionally been reported in patients who have received phenothiazines. In some cases death was apparently due to cardiac arrest, in others the cause appeared to be asphyxia due to failure of the cough reflex. In some patients the cause could not be determined, nor could it be established that death was due to the phenothiazine.

Drowsiness: May occur particularly during the first or second week, after which it generally disappears. If troublesome, lower the dosage.

Jaundice: Incidence is low. When it occurs (usually between the second and fourth weeks of therapy) it is generally regarded as a sensitivity reaction. The clinical picture resembles infectious hepatitis with laboratory features of obstructive jaundice. It is usually reversible although chronic jaundice has been reported with phenothiazine therapy.

Hematological Disorders: Agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenia purpura and pancytopenia.

Agranulocytosis: Most cases have occurred between the fourth and tenth weeks of therapy. Patients should be watched closely during that period for the sudden appearance of sore throat or other signs of infection. If white blood count and differential show significant cellular depression, discontinue the drug and start appropriate therapy. A slightly lowered white count, however, is not in itself an indication to discontinue the drug.

Cardiovascular: Postural hypotension, tachycardia (especially following rapid increase in dosage), bradycardia, cardiac arrest, faintness and dizziness. Occasionally the hypotensive effect may produce a shock-like condition. In the event a vasoconstrictor is required, levarterenol and phenylephrine are the most suitable. Other pressor agents, including epinephrine, should not be used because a paradoxical further lowering of the blood pressure may ensue.

EKG changes, nonspecific, usually reversible, have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.

CNS Effects: Neuromuscular (extrapyramidal) Reactions: These are usually dose related and take three forms: (1) pseudoparkinsonism; (2) akathisia; and (3) dystonias (Dystonias include spasms of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, eyes rolled back, convulsions, trismus and swallowing difficulties). These resemble serious neurological disorders but usually subside within 48 hours. Management of the extrapyramidal symptoms, depending upon the type and severity, includes sedation, injectable diphenhydramine, and the use of antiparkinsonism agents.

Hyperreflexia has been reported in the newborn when a phenothiazine was used during pregnancy.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of the mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; anti-parkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Other CNS Effects: Cerebral edema. Abnormality of cerebral spinal fluid proteins. Convulsive seizures, particularly in patients with EEG abnormalities or a history of such disorders. Hyperpyrexia.

Adverse Behavioral Effects: Paradoxical exacerbation of psychotic symptoms.

Allergic Reactions: Urticaria, itching, erythema, photosensitivity (avoid undue exposure to the sun), eczema. Severe reactions include: exfoliative dermatitis (rare); contact dermatitis in nursing personnel administering the drug; asthma; laryngeal edema; angioneurotic edema; and anaphylactoid reactions.

Endocrine Disorders: Lactation and moderate breast engorgement in females and gynecomastia in males on large doses; changes in libido; false-positive pregnancy tests; amenorrhea; hyperglycemia, hypoglycemia, glycosuria.

Autonomic Reactions: Dry mouth, nasal congestion, constipation, adynamic ileus, myosis, mydriasis, urinary retention.

Special Considerations in Long-term Therapy: After prolonged administration of phenothiazines, pigmentation of the skin has occurred chiefly in the exposed areas, especially in females on large doses. Ocular changes consisting of deposition of fine particulate matter in the cornea and lens, progressing in more severe cases to star-shaped lenticular opacities; epithelial keratopathies; pigmentary retinopathy.

Other Adverse Reactions: Increases in appetite and weight; peripheral edema.

DOSAGE AND ADMINISTRATION: Dosage should be individualized, not only initially but during the course of therapy, and the minimal effective dose should always be employed. A starting dosage of 10 mg. two to four times daily is recommended for adults. The dose may be increased up to 160 mg. daily within a three to five day period. Should side effects occur, dosage should be reduced or discontinued as indicated. For maintenance therapy, up to 160 mg. daily in divided doses may be given.

OVERDOSAGE WITH PHENOTHIAZINES:
Manifestations: One of three clinical pictures may be seen.

1. Extreme somnolence; patient can usually be roused with prodding, but if permitted will fall asleep. General condition is usually satisfactory. The skin, though pale, is warm and dry. Slight blood pressure, respiratory and pulse changes may occur but are not problems.
2. Mild to moderate drop in blood pressure (patient may be conscious or unconscious). Skin is markedly gray but warm and dry. Nail beds are pink. Respiration is slow and regular. Pulse is strong but rate slightly increased.
3. Severe hypotension, possibly accompanied by weakness, cyanosis, perspiration, rapid thready pulse and respiratory depression.

Treatment: Is essentially symptomatic and supportive. Early gastric lavage and intestinal purges may help. Centrally acting emetics may not help because of the possible antiemetic effect of QUIDE. Give hot tea or coffee. Severe hypotension usually responds to measures described under hypotensive effects (see ADVERSE REACTIONS: *Cardiovascular).* Additional measures include pressure bandages to lower limbs, oxygen and I.V. fluids.

Avoid stimulants that may cause convulsions (e.g., picrotoxin and pentylenetetrazol).

Limited experience with dialysis indicates that it is not helpful.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED:

QUIDE (piperacetazine) Tablets—10 mg. (orange)—bottles of 100 (NDC 183-52-2), and bottles of 1000 (NDC 183-52-4).

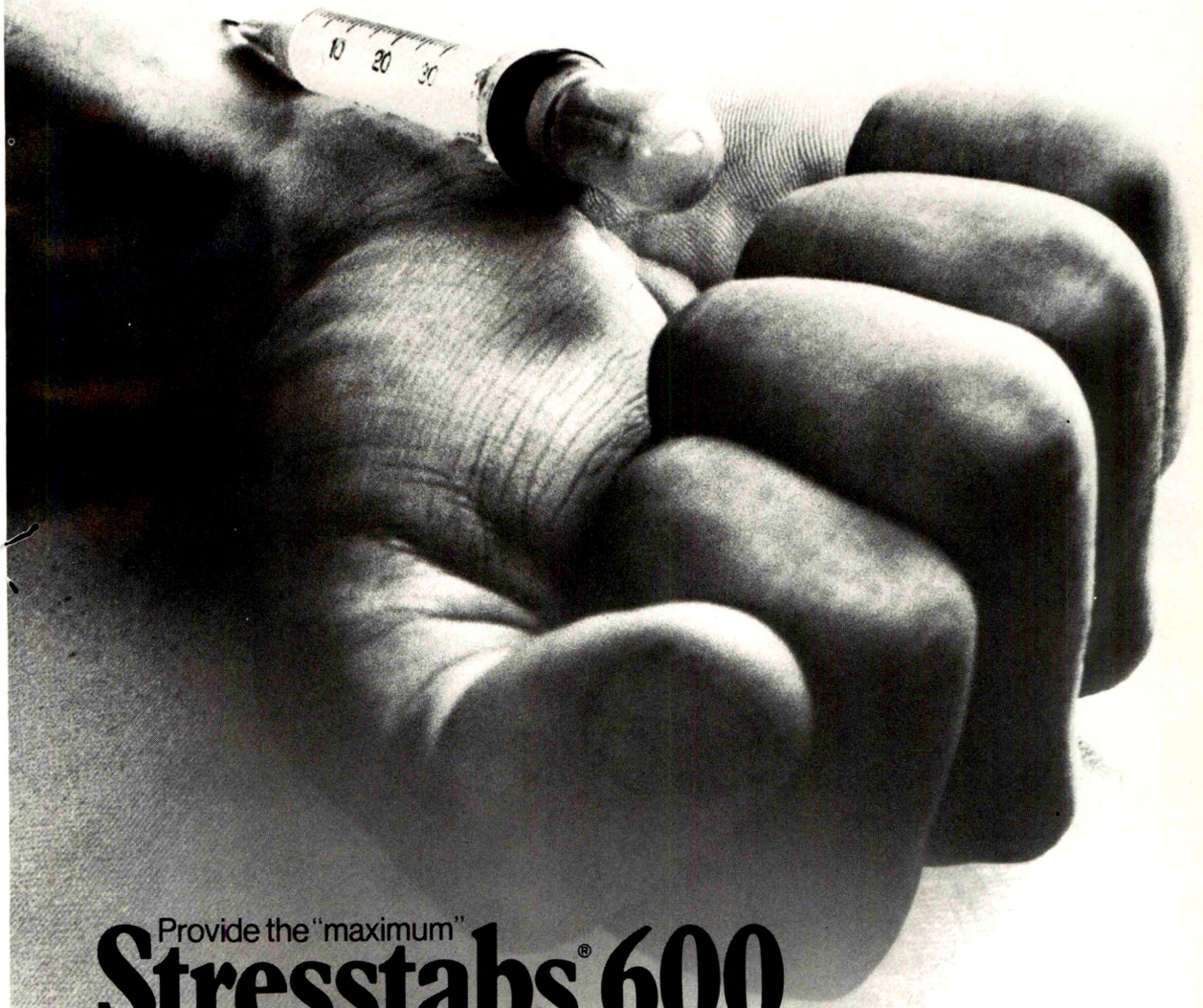
QUIDE (piperacetazine) Tablets—25 mg. (yellow)—bottles of 100 (NDC 183-53-2), and bottles of 1000 (NDC 183-53-4).

Note: Dispense only in light-resistant containers; the coatings on these tablets contain light-sensitive colors.

January 1973

DOW **DOW PHARMACEUTICALS** The Dow Chemical Company Indianapolis, Indiana

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

High Potency Stress Formula Vitamins

Each Tablet Contains:

Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3

HELP KEEP HIM OUT OF THE BAR



Bars may draw him like a magnet. Not for social reasons as much as antisocial ones. His drinking hurts himself and others close to him. He's an alcoholic, a public health problem, and a menace behind the wheel of a car. He's ill and needs your help and treatment.

For more than 20 years now, ANTABUSE has proved its effectiveness as a medical adjunct in the management of alcoholics who want to recover. ANTABUSE offers strong deterrent action. It can help keep the alcoholic sober so that he can participate in a total treatment program utilizing many supportive measures.

Once the alcoholic accepts ANTABUSE therapy, he has made his decision to stop drinking. By taking his tablet each day, he daily strengthens his resolve. The patient must be given a clear and detailed description of the effects of ingesting alcohol after he has taken ANTABUSE even up to 14 days after the last dose. ANTABUSE is nonhabituating; there is no danger of cross-addiction.

ANTABUSE®

Brand of DISULFIRAM

a strong deterrent for the alcoholic who doesn't want to drink

See opposite page for brief summary of prescribing information.

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning in humans. Animal studies have shown that physostigmine also reverses certain toxic effects of protriptyline, but to a lesser extent.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 — 5 mg (orange)

MSD 47 — 10 mg (yellow)

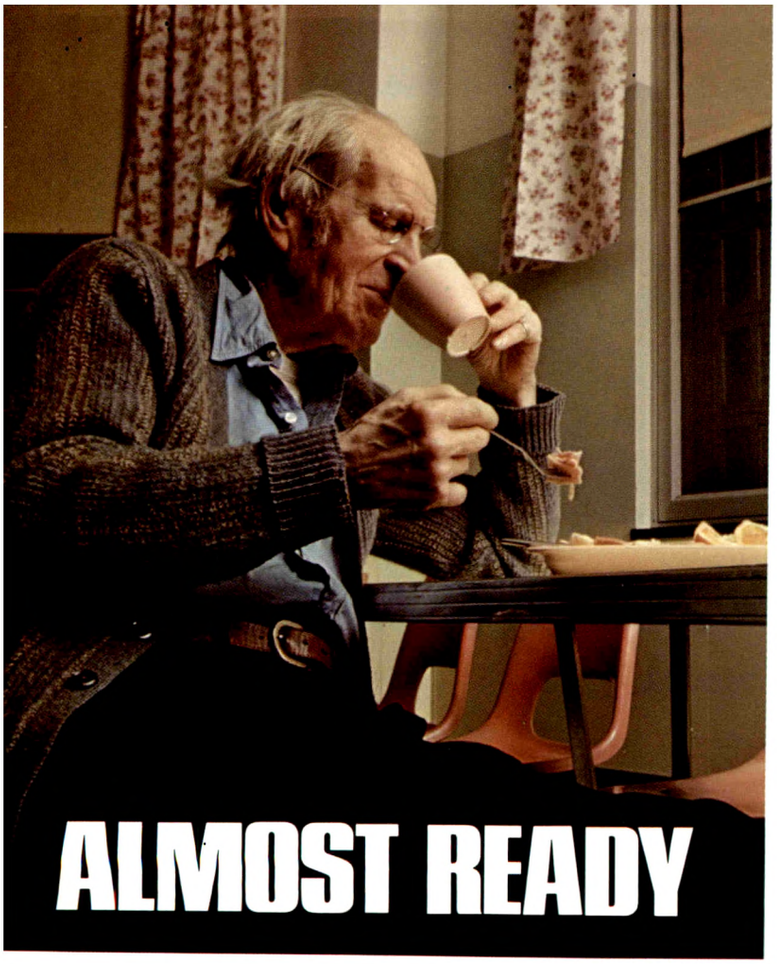
The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)



ALMOST READY

Now that he's better able to take care of his own needs, referral to a nursing home may be a therapeutic possibility.

Participation in the therapeutic program is most often the most difficult hurdle the chronic psychotic patient has to overcome. For patients with psychotic disorders, medication is often basic to the treatment program that bridges the gap between hospital and nursing home.

With Mellaril, patients are generally alert and in better contact with reality and can participate more fully in the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

MELLARIL®
(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic disorders

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

73-797

SANDOZ

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERSEY 07936

Presidential Papers: 1973

745 The Presidential Address: A Time for Action
Perry C. Talkington

748 Response to the Presidential Address
Alfred M. Freedman

750 Perry Clement Talkington, M.D., One Hundred and First President, 1972–1973
Henry W. Brosin



PERRY C. TALKINGTON, M.D.

PRESIDENTIAL PAPERS: 1973

The Presidential Address: A Time for Action

BY PERRY C. TALKINGTON, M.D.

OUR PROFESSION is under attack, both internally and externally. We live in a milieu in which major forces direct themselves to the needs of mass society rather than to the needs of the individual man, woman, and child. Civilized life has become so thoroughly political that it makes the life of the individual seem trifling. The theory and rhetoric of our times submerge the fundamental reality that sick people have individual differences and require highly individualized care. Proposals for total health care systems harbor within them pressures that would separate physicians generally, and psychiatrists in particular, from their patients. Economists who appear to know the cost of everything but fall short in their perception of human values would reduce the members of a learned profession to vendors of goods and services in the medical marketplace. The unity of humanism and biological medicine that sustained us in the early 20th century no longer exists.

The courts of our nation impinge upon us even to the point of dictating whether our patients shall or shall not have medication.

State administrations, as a matter of public policy, are transferring psychiatrically helpless and defenseless patients to the welfare system or to jail.

The Food and Drug Administration and the Department of Justice usurp the right of the physician to determine the drugs he will prescribe.

There is widespread belief in powerful circles that medicine must be planned, organized, managed, coordinated, staffed, motivated, and controlled by agencies outside of the medical profession and under the aegis of the federal government, third-party payers, or both. The "Megaplan," a working document of the Department of Health, Education, and Welfare, speaks of using "the might of government" to force changes in the health care delivery system—changes that could ultimately establish rigid fee and price schedules for physicians and hospitals, bring government controls over research, and initiate federal intervention in medical ethics. Most national health proposals forthrightly declare their intent to control the quality of health care through the power of funding mechanisms.

Medicine continues to be singled out for special controls under the wage-price freeze, and some theorists would drastically alter present patterns of private psychiatric practice.

There is widespread demand for the initiation of a massive quasi-medical, quasi-scientific, so-called "treatment" program for masses of people on a nationwide scale. Those who most strongly support this proposition would separate the psychiatrist from his patient and psychiatry as a whole from the rest of medicine. It is argued that only by breaking with medicine and abandoning patients can psychiatry become a prime force in bringing about the sweeping social changes said to be essential to building a healthy society. Indeed, it may be that as many as 20 percent of American psychiatrists are willing to abandon the patient and "politicize" medicine for the purpose of social reform.

As though to reinforce the trend, our medical schools and our graduate education centers each year drift farther away from the biological and clinical approaches to mental illness and thereby place our medical tradition in ever-greater jeopardy. In the past decade or so we have seen the establishment of some 20 new medical schools, and there is constant pressure on them to double their output. This implies a reduction in their standards of excellence for their graduates. Medical curricula are curtailed, internships abolished, and training periods shortened. Specialized track systems permit graduation from medical school without *any* exposure to psychiatry. It is now possible for a would-be psychiatrist to complete residency training with little or no clinical experience in treating mentally sick people. Much is made of the great value of interdisciplinary training in the preparation of psychiatrists, but with it there is also the danger of diffusing the role of psychiatry as a medical specialty.

In spite of the range, breadth, and complexity of psychiatry and its many treatment modalities, we now hear a

Read at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Talkington was 101st President of the American Psychiatric Association. He is Senior Consultant in Psychiatry, Timberlawn Psychiatric Center, 4645 Samuell Blvd., Dallas, Tex. 75228, and Clinical Professor, Southwestern Medical School, University of Texas, Dallas.

simple syllogism: that psychiatry is limited to the single technical treatment modality of psychotherapy, that anyone can do "psychotherapy," and that therefore psychiatrists are unnecessary. We are told by some that there is no such thing as mental illness; that our hospitals are illegal and immoral and essentially "prisons"; that any provision for the involuntary commitment of patients is evil; and that the people would not perish if our profession were dispensed with altogether.

The federal government, which so long nourished our growth, has now determined to withhold further support for training in psychiatry, as though to hasten our demise by drying up our source of supply. Without youth input, psychiatry will die.

And so it is that one hears the executive director of a lauded community mental health center venture that, in his opinion, "within 25 years, professional roles in mental health, especially those of psychiatrists, will be obsolete."

In summary, then, I submit that if the trend toward abandoning the medical treatment of patients and the trend toward lowering medical educational standards continue unabated, the medical profession may again reduce the care of the mentally distressed to a low priority. Throughout history, when this has occurred some patients have died, some have been killed, some have been tortured, and some have been burned as witches. Will we permit this to happen again?

THE POSITIVE ASPECT

The past 25 years have brought a greater understanding and more effective treatment of neurological and psychiatric disorders than had been achieved in all the previous history of civilization. Our profession stands on the verge of unprecedented growth in the knowledge of the genetic, biological, psychological, and pharmacological mechanisms that operate in the major psychoses.

I call your attention to the fact that for the majority of American people, psychiatric services are approaching—and in some cases have already reached—the saturation point. Public and private psychiatric hospital care is available to the seriously ill everywhere. Community general hospitals are rapidly expanding their capacity to provide a wide range of psychiatric services. Appointments with private practitioners of psychiatry are available in every one of the 200 major cities of America, and new patients can be seen on a walk-in basis in most of about 400 operating community mental health centers throughout the land.

I am told that the private sector of psychiatry has become a massive national resource that in its private offices, its general and private psychiatric hospitals, and its various modalities of group practice meets the treatment needs of about half of all emotionally disturbed patients who seek treatment. More than 2,000 institutions and agencies, public and private, now help cover the costs of psychiatric care. The insurability of the psychiatric illnesses has long since been demonstrated.

Many leaders in academic psychiatry are now recommending a return to four years of undergraduate medical education, uncrowded classes, a return to the internship, and the lengthening of residency programs. There is a resurgence in the belief, so long held dear in medicine, that medical schools should guarantee a graduate product that leaves no doubt of his identity as a true physician and a humane clinical scientist.

A large and growing segment of American psychiatry is reaffirming that the primary mission of the psychiatrist is to treat the sick in the time-tested physician-patient relationship and that the primary mission of psychiatric education is to impart to the psychiatrist the basic clinical skills necessary to do so. There are some residency programs that refuse to accept applicants who have not completed internships. Still others provide for preceptorships with general practitioners in psychiatry. Tolerance, openmindedness, and eclecticism have ever been the hallmarks of American psychiatry; the pendulum, which had shifted so strongly toward the treatment of the neuroses and character disorders, is now swinging toward greater understanding of the causes and treatment of the psychoses.

We think we detect a fairly widespread reaction against uncritical acceptance of new and untried therapeutic approaches and against haste, intellectual laxity, creeping mediocrity, and the impersonalization of treatment procedures.

There are growing reactions against the proposition that all funding of America's medical care should be government funding. There is growing conviction that we can and must stem the tide of invasion of privacy in our culture—most especially as it impinges upon the confidentiality of the doctor-patient relationship.

The most critical problems of psychiatry have centered in the public sector, and today we hear a plea for an even distribution of the miracles of modern medicine. The plea is couched in terms of "crisis." In searching for gaps in the distribution of psychiatric services, we find no crises. There *are* problems. If, in the interest of human dignity, there are to be no charity patients, then there is the problem of finding funds for ambulatory care of that segment of our population. There are problems of access, problems of transportation, and problems of education and manpower distribution. Among the poor there is a reaction against care by indigenous workers and paraprofessionals; they want quality care. They are our allies in the quest for such care for all Americans.

Under the umbrella of this vast, complex, and magnificent Association of ours stand many kinds of psychiatries and many kinds of psychiatrists. But we can be sure that psychiatrists who clearly identify themselves as medical doctors will continue in demand so long as there are emotionally disturbed people on this earth.

Across the nation there is a deep-seated, legitimate sense of urgency, concern, and determination that our profession will shape its own future. We feel a sense of outrage that the mentally ill are blown by every breath of political change.

In this spirit you, the American Psychiatric Association, have demonstrated the economic feasibility of in-

cluding psychiatric illness in any health insurance program, be it public or private. You have embarked on a major effort to establish a second Joint Commission on Mental Illness and Health. You and your fellow members are in the process of identifying all gaps in the delivery of psychiatric services and in setting priorities for their closure. Your representatives have repeatedly pleaded the cause of the mentally ill before the platform committees of both political parties, before state legislatures, and before the Congress of the United States. They are being heard.

You have made great strides in increasing the coverage of the mentally ill under health insurance programs. However, even in the face of incontrovertible evidence there are those in the halls of government who continue to tell us that mental illness is too expensive to be given equal coverage with other illnesses and that the proposed health maintenance organizations will be too weak to provide psychiatric treatment.

We are confronted with a labyrinth of philosophies and contradictions reflected in the 93rd Congress. There are those who want a national health program for *all* people. There are those who want it for *some* people. There are those who plead for the coverage of catastrophic illness only. There are those who are for and those who are against continuing federal funding for community mental health centers and psychiatric education and research. There are those who are dedicated to the continued development of the private sector of medicine, and there are those who would severely restrict it and reshape it by government edict. They are more than willing to hear us.

But our voices are not loud enough. If we are to be faithful to our covenant with the mentally ill, it is time now for action.

SIX RECOMMENDATIONS

It is therefore my recommendation that we proceed to meet the challenge in these ways:

First, every district branch has its legislative representative. The American Psychiatric Association has held two Institutes on Government Operations to enhance the members' sophistication in legislative affairs and the political process. A special newsletter now informs them in detail of legislative developments at the national level. It is time now for the district branches to organize their representatives into a nationwide legislative network that can mobilize support for the cause of the mentally ill.

Second, in order to coordinate and implement an effective legislative network, it will be necessary to expand the staff and activities of the government relations operation in our central office in Washington, D.C. The present dues structure will not fund such an expansion, but we must be willing to foot the bill, whatever it may be.

Third, we must change the climate of public opinion, tell the story of the benefits and effectiveness of psychiatry, and form liaisons and coalitions with the scores of organizations and agencies that have a deep and abiding concern with the fate of the mentally ill in America.

Fourth, the first Joint Commission on Mental Illness and Health captured the attention of Americans and stimulated their action. The achievements of that commission and of the Joint Commission on Mental Health of Children are memorable. It is time now to follow through with a second Joint Commission on Mental Illness and Health. It must proceed from the assumptions that the profession of psychiatry is and must remain a medical specialty and that it does have the knowledge and the will to bring adequate psychiatric care to all Americans. Through the mechanism of a second Joint Commission we can reawaken the national conscience in support of the advancement of the treatment and care of the mentally ill.

Fifth, I submit it is now time to develop a psychiatric political action committee *outside* the framework of the American Psychiatric Association—one that can be truly effective in the world of power politics.

Sixth, and finally, Americans today have access to the finest psychiatric care on earth. We must see that *all* Americans have access to it. We must emphasize our unshakable demand that the cost of psychiatric care be covered under any health insurance program that may evolve.

The challenge is great. The time is right. If we can fulfill our covenant, we will be remembered as the pioneers of a new era in American psychiatry.

Response to the Presidential Address

BY ALFRED M. FREEDMAN, M.D.

A REVIEW OF THE VOLUME of past valedictory speeches of Presidents of the American Psychiatric Association reveals a consistent pattern. Each of our distinguished leaders surveyed the theory and practice of psychiatry at the time he made his address. Some approached their task historically, while others focused upon the moment. Then, appropriately enough, each looked to where the road ahead might lead.

Consistent with this tradition, Dr. Talkington has presented his view of the state of the profession and where we seem to be bound. I wish to join Dr. Talkington in his emphasis on furthering the comprehension of the etiology of serious mental illness and on the advancement of treatment of the seriously mentally ill. I join him in his commitment to the finest psychiatric care for all Americans who need it.

Can these and the other noble aspirations we share be realized? What are the obstacles to their implementation?

Dr. Talkington has wisely stated that we cannot avoid the pressure of social forces. If psychiatry is indeed "beleaguered," its problems must be viewed as part of a general crisis of confidence in all of the major institutions and authority figures in our society. During World War II, the seriousness and extent of mental disability first revealed during World War I was rediscovered. There followed two decades in which psychiatry was proud of its past and confident of its future.

For the past few years, however, we have fallen into pessimism. We have tended to see futility in our efforts and failure in our achievements. We have believed ourselves to be surrounded by hypocrisy and aggression. In the face of problems that seemingly could neither be ignored nor solved, professional esprit diminished and, not surprisingly, so did the esteem in which psychiatry was held.

It is noteworthy that these peaks and troughs of credibility have occurred in other sectors as well. A recent Harris poll on public confidence in authority figures, comparing 1966 with 1972, showed not only a drop in confidence in psychiatrists but in physicians in general, in Supreme Court Justices, in businessmen, and in scientists.

However, as Dr. Talkington has emphasized, this is a time for action, not for despair. Psychiatry's achievements in the postwar period remain: new developments in treatment methods, including impressive advances in psychopharmacology and in group and family therapy and behavior therapy; new methods of delivery of mental health services, such as the community mental health centers; and new developments in the care of the seriously ill, such as the open hospital and the therapeutic community. All these point to progress.

Read at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Freedman is 102nd President of the American Psychiatric Association. He is Professor and Chairman, Department of Psychiatry, New York Medical College, 5 East 102nd St., New York, N.Y. 10029.

SOME UNRESOLVED PROBLEMS

And yet we have a number of unresolved problems to face. Through this last year as President-Elect of the Association, I have tried to formulate the issues in four parsimonious categories.

First, we must be prepared to defend the validity of our field without apology. The public needs from the profession reasoned statements about the existence of mental illness and its scientific basis; modest statements about current knowledge in diagnosis and treatment; and discriminating statements about medical care, treatment modalities, and allied services.

Second, we must come to some agreement about the appropriate role of the psychiatrist. Once having postulated the existence of mental illness, we can surely begin with a definition: a psychiatrist—that is to say, a physician with specialty training—is uniquely an individual proficient in diagnosis and in administering treatment that utilizes biological, pharmacological, psychological, or social means. But that is only a beginning.

It leads to a third category: the work patterns of a psychiatrist—what he does and where he does it—and the nature of his specific contribution to patient care. Together we must go on to explore and delimit the boundaries of our profession and achieve a set of living and working relationships with the others who inhabit the territory.

Finally, we face the critical question of the legitimacy of our field. Dr. Talkington has referred to the spate of criticism and opposition and even virulent attacks upon both the theory and practice of psychiatry. These have come from a variety of sources—from members of our own profession and other mental health professions and from lawyers, consumer advocates, and former patients. Some of this opposition has been stated in the most uncompromising terms. I have in mind here such areas of contention as the appropriateness and legitimacy of hospitalization and commitment.

And yet I have been struck in polls done by my own department at the New York Medical College in East Harlem—one of the most impoverished ghetto areas in the

nation—by the insistent request for more and better services: services for children, for the aged, for the heroin addict. The major concern is not the fear of harm from the profession, but how to get more services, more help, in ways that are immediately accessible to the residents of the area.

The conflicting messages that we receive from most of our critics and from different sections of the community seem to me to have one important element in common: they are motivated by the desire for excellent and humanitarian patient care.

The existence of criticism and the demands for participation need not be interpreted apocalyptically as signs of doom. The key to restoring confidence in the profession is to discover those programs—if you will, those reforms—which can be supported by different factions, even if for different reasons. The times are difficult. Even more critical institutions in American life seem to be coming apart. For us, as for others, fragmentation is a serious and basic problem. I should add that I use this word in two senses—as a description of the proliferation of tendencies and views around any subject of concern and in the sense of bomb fragments, those pieces which remain after an institution is shaken to its foundations.

For our own profession, we have the job of putting together at least some of the pieces, a task of mending and healing analogous to the burdens of patient care. We can only do that job together with those of goodwill outside the profession—*including* our critics. The spirit in which we should approach this task was expressed by the political scientist John Schaar, in the context of the relationship between teacher and student. But it is, I think, easily transferred to our own situation. To be effective, our work must grow from "a spirit of humility." We too must overcome any "tendencies toward self-righteousness and self-pity" and in our dealings with others stress "connection and membership, rather than distance and superiority" (1).

Finally, I see in our work the necessity for combining action and knowledge in such a way that new knowledge draws on the memory of past action. Thus, Dr. Talkington has presented us with a twofold challenge: to extend our knowledge on the foundations laid down by him and those who went before, and to *act* in such a way ourselves as to produce new possibilities for those who come after.

REFERENCE

1. Schaar JH: The case for patriotism, in American Review, vol 17. Edited by Solotaroff T. New York, Bantam Books, 1973, pp 59–99

Perry Clement Talkington, M.D.
One Hundred and First President, 1972–1973

BY HENRY W. BROSIN, M.D.

THOSE WHO COME AFTER US and search biographies for enlightenment may well inquire about the qualities of mind and heart to be found in the men and women who were in leadership positions during this turbulent period, and by what process they emerged. Every society, so it has been said, produces leaders needed for the problems faced by its members during periods of great unrest. This might be said about the 101st President of the American Psychiatric Association in the 129th year of its existence. Like some of his predecessors, Perry Clement Talkington brings imposing credentials as an informed man of action: keen, experienced, knowledgeable, one who is able to deal effectively with complex personnel, fiscal, and administrative problems.

During the term of President Talkington we have had all grades of opinion regarding the future functions of a psychiatrist, from conventional medical models following Hippocrates, Osler, and Peabody, who highly valued service to patients and excellence as skilled professional workers, to those who want to politicize all professions. There are those who do not insist on excellence as the sine qua non for a physician, thereby inviting the creation of several different classes of physicians. There are even those who want to destroy APA entirely.

FAMILY BACKGROUND

If one had the time it would be of more than ordinary interest to trace the genealogy of the Talkingtons and the Clements from their European origins to their 18th-century transition to the United States, and their various transformations as pioneers going ever westward in both the north and the south. The Talkingtons apparently came originally from the Thors estate in Cheshire, England. Great-grandfather Isaac Walton Talkington was graduated from Cane Hill College in Fayetteville, Ark. Of Grandfather Perry John Talkington it is recorded that "he was a progressive citizen, a consistent Christian, and a staunch prohibitionist who helped formulate a plan for state-wide prohibition" in Texas. After three years of college, Perry John enlisted in the Confederate Army. In time he was captured by Federal troops and spent ten months as a prisoner of war in Illinois. After the Civil War, Perry John settled down on a farm in Hopkins County near Nelta, Tex., married Hautensia Pearce, also from a long line of farmers and preachers, some of whom attained distinction as legislators, soldiers, and physicians. They had two sons, Thomas Walton, the father of President Talkington, and Arthur, who died at a relatively early age, and six daughters, all of whom married.

While almost all of us have forebears who lived lives of toil, hardship, and drama during the evolving centuries, I believe that Thomas Walton Talkington is especially deserving of a full-length biography. He was born on a farm in Hopkins County, Tex., about 100 miles from Dallas. He went first to Eastland College in East Texas and then to Baylor, where he achieved his A.B. and Th.B. in 1903 and his Th.D. in 1911. He was able to do all this by working his way through school as a printer and preaching in small churches. These occupations did not prevent him from being a member of the varsity basketball team for three years, a member of the Philomathesian Literary Society, and something of a musician with the bass viol. After his long apprenticeship and five degrees, he went to the Oklahoma Baptist University, where he held the chair of Bible and ancient languages. His long and complex active ministry, during which he established churches both large and small, included being the pastor of churches in Hastings, Okla., Beaumont, Tex., Homer and Bogalusa, La., Ozark, Ala., and Crystal Springs and Sumerall, Miss.

If we can define a modern thinker as an individual who sees the ills of the world—its sickness, its inequities, its wars, and its injustices—then Thomas Walton Talkington was a modern thinker to about the same extent as were Euripides, Plato, Sir Thomas More, and today's liberals. He understood grinding poverty, racism, class war, and culture conflicts from his own background of experience and from his knowledge of classical literature. Being well traveled, he understood the plight of blacks all over the United States, but his heart particularly bled for those whom he knew in the deep south. At the age of 66 he began working for the next 20 years as Dean of the Negro Southeast Center Mississippi Baptist Seminary in Hattiesburg. (This probably was not a popular thing to do 27 years ago.) At 86 years of age he retired gracefully, in full possession of his faculties.

We are all too familiar with the scholar-executive-man-of-affairs who is seldom home. It is a pleasure to record that our President learned to hunt and fish from his father because he grew up in a time when it was necessary to be a good marksman and a good fisherman to add to the family larder. Our President tells us:

> I think I also learned from him how a man is supposed to think, act, and feel, what his place is in the home, what are

Dr. Brosin is Professor of Psychiatry, University of Arizona College of Medicine, Tucson, Ariz. 85721.

the responsibilities of a husband and father, but most of all I suppose he set an example of a firm belief in something, devotion, a sense of duty, and that, by God, everything was not all right in this best of all possible worlds. I learned from him patience, and understanding, and righteous indignation.

We must now turn to his mother and the Clement family to learn the other side of our President's heritage. Clement is an ancient Roman name; it was among the French Huguenots who came to America, many of them by way of Holland in the 17th and 18th centuries. The first Clement known in America was a devout French Huguenot who sailed the Hudson River trading with Indians for furs. Grandmother Elizabeth Clement's ancestors entered the United States via Savannah, Ga. She was born in Pea Ridge, Ark., but her family, the Burks, moved on to Bell County, Tex., next door to the Clements in Waco. The mother, Dora Geneva Clement Talkington, and her sister were graduated from Baylor Academy with bachelor's degrees—Dora in 1907, the same year she married Thomas Walton Talkington. In summary, in the six generations up to 1957 there had been in the family on both sides 11 teachers, seven physicians, one Congressman, one Certified Public Accountant, one missionary, five ministers, and eight members of the Armed Forces.

Dora Talkington worked in virtually every department known in Baptist churches. She taught Sunday school classes for 38 years and wrote Sunday school lessons for the Standard Publishing Company for Methodist churches. She was also head of the English department in the Sumerall, Miss., High School, and for nine years taught in the Mississippi Baptist Seminary. Her stories were published in women's and children's magazines. Now, aged 85 and invalided, her last published article had to do with the new values, motivations, and appreciations of friendship engendered by a stroke. Obviously this working mother had ample resources, external and internal, to combat the commonplace philosophic loneliness of the Romantic period, or the isolation and existential despair that are now prevalent in many circles. The mother of four children, she carved several careers for herself with the opportunities at hand.

THE EARLY YEARS

Our President, a third-generation Texan, was born in Waco on August 28, 1909, the oldest of four children. His brother Arthur was born when Perry was two and a half years old and died at two and a half years of age. His sister, Odessa, six years younger than Perry, had a brilliant school and college record, taught for a while, and then married Elton McAmis, an internist in Natchez, Miss. They have a son, Lee, recently graduated from Tulane Medical School, who is now in residency training in psychiatry. Another brother, Thomas Walton, 13 years younger than Perry, was graduated summa cum laude from the University of Mississippi and became number three in his medical school class at Tulane. He is now an orthopedic surgeon in Jackson, Miss.

In his seventh or eighth year, Perry began to devour hardback books and started studying the violin. He had heard much classical literature read to the children by their mother, and he read through his father's voluminous classical library. He discovered that teachers of English literature were rather limited. A single example will suffice: he was assigned *Ivanhoe* for the seventh time in college after repeated exposures in grade school and high school.

Perry became president of Sunday school classes, Baptist Young Peoples Union groups, and his senior class in high school; he earned nine letters in football, basketball, and track and played first violin in the high school orchestra, in the church, and in the local theater. He worked in a grocery store on Saturdays and in the lumberyard and planing mill during the summers.

COLLEGE AND MEDICAL SCHOOL

Perry entered Howard College in Birmingham, Ala., and earned a freshman numeral in football. His big intellectual adventure was the discovery of chemistry and physics. His major interest in the sciences paralleled the premedical course; this, coupled with his liking for people and the fact that medicine offered a life of service to others, made his choice of occupation simple. He worked as an usher, musician, and assistant manager of a Loew's theater to help pay expenses. During his sophomore year football practice would have interfered with laboratory work, so he transferred to Baylor University, back to where he was born, having lived in nine other cities in the meantime.

During his sophomore year at Baylor, Perry became a student instructor in zoology and president of the premed club. He continued to play the violin in a restaurant orchestra and in dance bands, and played string bass in the Baylor Symphony Orchestra for two years. He also sold women's shoes afternoons and Saturdays. During the summers he loaded boxcars in Mississippi.

During his four years at the Baylor University Medical School (1930 to 1934) he found the greatest intellectual stimulation of his life up to that time, outside of his highly literate and articulate parents. He continued to earn his way by waiting on tables and plugging the PBX board at the Baylor Hospital, ending up with the euphemistic title of night superintendent. He met his future wife, Ruth Elizabeth Torian, during his first year. She was graduated as a mathematics major from Baylor in 1932 and taught mathematics and science at the Buckner Orphan's Home in Dallas. They were married on June 25, 1934, after Perry received his M.D. degree on May 28. In spite of his several jobs and the joys of courtship, he finished 11th in a class that started with 128. He had become interested in both neurology and psychiatry at the beginning of his junior year, due to the influence of James Terrell, Guy Witt, and Thomas Cheavens. It was a fateful meeting, for it gave direction to Perry's professional life.

THE FAMILY

Ruth was a fifth-generation Texan, so their decision after residency training to settle in Dallas was relatively uncomplicated. They had three children, and there are now four grandchildren.

The Talkingtons' older son, Paul Clement Talkington, is 32 years old; he is married and has two children. He was selected as one of the ten outstanding students of Rice University by the student body and the faculty and earned an M.B.A. at the Harvard Business School. He is a stock analyst and vice-president of Medenco, Inc., in Houston, which supplies hospitals and medical laboratories.

The younger son, Robert Walton Talkington, is 30 years of age and lives in Dallas with his wife and two daughters. He received his B.A. degree from Baylor University and his M.B.A. from the Wharton School of Finance and Commerce of the University of Pennsylvania. By way of General Telephone and Electronics, he has gone to Lomas Nettleton, the biggest mortgage loan company in America.

President Talkington's daughter, Ruth Lynn, now Mrs. Clifton Paul Rogers III, was graduated from the University of Texas. Her husband is an attorney, and they live in Stroudsburg, Pa.

RESIDENCY TRAINING

After a rotating internship at a general hospital in Erie, Pa., Perry chose a residency at the state hospital at Taunton, Mass., where Ralph Chambers was superintendent. He could hardly have done much better in his choice of an intellectual center to learn about the methods and concepts then current in neurology and psychiatry, for he met Douglas Singer, C. McFee Campbell, Harry Solomon, Winfred Overholser, Stanley Cobb, Tracy Putnam, and Abraham Myerson, who were among the best men in the U.S. for three decades. It was a rich experience. After two years he went to Philadelphia for his training in neurology, for it was still expected by many patients and doctors that the same doctor do both neurology and psychiatry.

At the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases there was probably the largest neurological service in the U.S.; there were 125 neurological beds and 10,000 outpatients annually. The senior staff was relatively small but very active, so Perry had an opportunity to work closely with Charles Burr, Frederick H. Leavitt, Joseph Yaskin, and Robert Groff. With Philip Q. Roche, Perry ran an outpatient clinic and presented cases at the famous Friday seminar at Graduate Hospital to outstanding visitors such as Foster Kennedy and Israel S. Wechsler of New York.

THE TIMBERLAWN HOSPITAL AND FOUNDATION

Ruth and Perry returned to Dallas in January 1946 with only one contract from Doctors Terrell, Witt, and Cheavens: "If you will come with us we promise you will never regret it." They never did. Timberlawn was a good psychiatric hospital. On the day Perry arrived in 1938 there were 19 patients and 35 employees. When Drs. Terrell and Witt founded Timberlawn Sanitarium in 1917, they had every intention of putting the best of American psychiatry under one roof, and their activities compared favorably with those in other select hospitals. These men worked seven days a week and stood shoulder to shoulder with other doctors in the area, making house calls and night calls, consulting with other physicians in homes and at the bedside, and appearing in court.

Dr. Terrell had been the first chairman of the department of psychiatry of the local medical school, and Dr. Witt had succeeded him as chairman. Dr. Terrell had become known as the best-loved physician in Texas. Dr. Witt in his time became the dean of Texas psychiatrists. Dr. Tom Cheavens, at the time of his sudden death in 1942 from a virulent meningitis while he was in the Navy, was voted by the Dallas Southern Clinical Society as the one physician that Dallas could least afford to lose. Among our President's several major accomplishments, Timberlawn is surely one of the most imposing, but the story must be told elsewhere.

SERVICE IN WORLD WAR II AND AFTER

Because he was a reserve officer, our President had the privilege of going on active duty January 19, 1941, ten months before Pearl Harbor. Like many others he went to Fort Sam Houston, originally for 12 months, but he stayed nearly three years (to November 23, 1943), acting as ward surgeon and traveling psychiatric consultant for the Eighth Service Command. (He was certified by the American Board of Psychiatry and Neurology in 1942.) In November 1943 he joined the Seventy-Ninth Infantry Division and did all the things that a divisional psychiatrist is supposed to do, including going on maneuvers with the infantry, participating in firing problems in artillery, and teaching nurses and almost 900 field officers about combat psychiatry, reactions to stress, and how best to prevent and manage them. In three months he returned to Fort Sam Houston to join the Third Army, first with General Hodges and later in England with General Patton. Here he performed the manifold duties of a field Army consultant in psychiatry. After the cessation of hostilities in the European Theater, Perry returned stateside to replace Colonel Franklin G. Ebaugh as consultant in psychiatry to the Eighth Service Command.

After the war was over our President joined the group of psychiatrists from all of the Armed Forces under the leadership of General William Menninger, who tried to help these services benefit from the lessons we had learned in World War II. Perry had many important appointments during the days of reorganization and far beyond as civilian consultant to the Surgeon General of the Army and as an officer of the Society of Medical Consultants to the Armed Forces.

POSTWAR ACTIVITIES

Upon his return to Dallas after an absence of 60 months, he assumed many of his old duties as a teacher of medical students, nurses, and residents, caring for private patients, and building up Timberlawn. Expansion began vigorously with Perry as the new chief; there are now 152 beds, with 56 more contemplated for adolescents. There are 24 senior psychiatrists, four Ph.D. psychologists, and six M.A. social workers. Timberlawn is affiliated with the Worden School of Social Work at Our Lady of the Lake College in San Antonio, and with the University of Texas School for Social Work. Although it is a proprietary hospital, Timberlawn is approved by the AMA-APA Residency Review Committee for a three-year resident training program for psychiatrists, and offers seminars for probation officers, ministers, psychologists, social workers, and nurses, and for those interested in day hospital operations, adolescent programs, and group, family, and conjoint therapies. Architecturally, it may now be the most copied psychiatric hospital in America.

Over 150 outpatients are seen daily, benefiting from as many of the new techniques as seem useful. It is an excellent modern hospital in the best sense of that complex term. Most of the senior staff are on the clinical faculty of the medical school. (Perry advanced through the ranks from an instructor in 1938 to clinical professor in psychiatry in 1969 at the University of Texas Southwestern Medical School. His publications, which are principally clinical and administrative, number 24, excluding book reviews and many speeches.) The faculty moved through the phases of physical and chemical treatments to a more dynamically oriented position in which they are back to treating people with people while retaining the best of other areas of therapy.

It would be absurd to try to describe even the major efforts of our President's civic activities in local organizations in Dallas and state activities centered in Austin. In one year alone he visited Austin seven times to help develop the Texas Mental Health Code after years of mental health planning and working for improved legislation. In other and more appropriate places, this part of the life of service of Perry Talkington can be told with attention to the total world scene. Only one sad note would interrupt the ongoing story of our President, namely the death of his wife Ruth on June 7, 1971, after his election to the office of President-Elect of APA. They had a wonderful, almost idyllic life together for 37 years, beyond the dreams of most of us. Her death was a shattering experience, with a period of severe distress at the loss of his central orientation to his world. Gradually the daily demands of life helped assuage the deep sorrow, and his executive energies returned to meet the ever-present challenges. Fortunately, he was able to find a longtime friend of the family, Mrs. Grace Knotts, with children of her own and who was well known to his children, to help him face the future. They were married on November 11, 1972.

ACTIVITIES IN APA

Since he has been an extremely active public leader in Dallas and in Texas as well as on the national scene in various capacities (the Army, the Central Neuropsychiatric Society, the National Association of Private Psychiatric Hospitals, the Southern Psychiatric Association, plus 12 other societies), there is little need to try to establish Perry's credentials as a leader. His APA activities include work in his district branch (president, 1965 to 1966) and his eventual selection, after serving as a Texas delegate or alternate (1958 to 1967), as the recorder and then Speaker of the Assembly of District Branches (1969 to 1970). He has been president of nine other organizations and a chairman or officer of many others.

In the midst of the many diverse public duties, which all bespeak a society in great ferment, one can detect a major theme beginning in 1962, when Perry became a member of the APA Insurance Commission and chairman of the APA Task Force on Prepaid Health Insurance, on which he served until 1969. In these new activities to bring APA in touch with the powerful economic surges of our current culture, our President became one of the three or four most knowledgeable and skillful leaders in the effort to help us learn how to provide better medical care for the economically deprived. He has stimulated the preliminary work to bring about a second Joint Commission on Mental Illness and Health and to aid in future planning he has encouraged the employment of the Rand-Delphi systems for the most accurate identification of gaps in the delivery of psychiatric services. His various presidential papers, including those to the Central Neuropsychiatric Association, the National Association for Private Psychiatric Hospitals, and the Assembly of District Branches, will attest to his mastery of the turbulent scene.

Our President is one of those strong leaders in a complex society who can learn how to adapt in a time of revolution, when old value systems are being assaulted and some are clearly being drastically altered. As a physician who was principally a private practitioner, yet who worked in both large and small city hospitals, a state hospital, a federal system, and a university system, he has been well equipped to meet the multiple demands of our complex and demanding society. The job specifications for our leadership now include, in addition to the classic demands for an abiding interest in patients, education, and research, a talent for and firsthand experience with managing large organizations, mastering the preparation of budgets, personnel management, negotiations with unions, and lobbying in Congress.

In the egalitarian days to come, perhaps a few will want to learn about the days when some physicians (not all by any means) were devoted to an ideal of service to their fellowman and found great fulfillment in this service. Such a scholarly reader will enjoy learning about the career of Perry Clement Talkington, a physician who loved people, took care of many of the distressed, and served his countrymen under many conditions, including days of poverty, war, and revolt.

A Dimethyltryptamine-Forming Enzyme in Human Blood

BY RICHARD J. WYATT, M.D., JUAN M. SAAVEDRA, M.D., AND JULIUS AXELROD, PH.D.

An enzyme capable of forming the hallucinogen dimethyltryptamine was found in human red blood cells, plasma, and platelets. The enzyme activity in red blood cells and plasma was not significantly different in psychiatric patients from that in normal subjects. The enzyme activity in platelets was higher in psychotic subjects than in nonpsychotics and was apparently related to the presence of a dialyzable inhibitor in the normal subjects.

FOR 20 YEARS there has been speculation about substances within the blood of certain groups of psychotic patients that are capable of producing psychotomimetic methylated amines (1, 2). The only agent known that is both psychotomimetic in man and possibly made in man is dimethyltryptamine (DMT) (3). In 1961, an enzyme in the lung of rabbits that N-dimethylated tryptamine to form DMT was described (4). Subsequently, Mandell and Morgan (5) described a similar enzyme in chick, sheep, and human brain. Saavedra and Axelrod also found an enzyme in human and rat brain that N-methylated tryptamine and, in addition, demonstrated that the rat brain was capable of forming DMT in vivo (6).

Because an abnormality in this enzyme could be related to psychosis, it seemed desirable to look for this enzyme in an easily accessible tissue and to examine whether there were differences in the activity of this enzyme in psychotic patients. This paper describes the presence of an N-methyltransferase that is capable of forming DMT in human blood, especially platelets. In order to demonstrate the problems in the search for and utilization of the tryptamine-methylating enzyme in man, the methods and results are presented in the chronological order in which they were done.

SUBJECTS

The subjects studied in this series of experiments were drawn from the following groups:

Normal subjects: selected from a group of normal volunteers and laboratory personnel at NIMH.

Alcoholic patients: chronic alcoholics who were free of physical illness, drugs, and alcohol during the preceding six months while hospitalized either voluntarily or by court order at the Washington, D.C., Rehabilitation Center for Alcoholics.

Psychotic depressives: a total of 13 patients with psychotic affective disorders who were studied at least two weeks after all drugs had been discontinued. The patients were hospitalized on NIMH research wards at either the Clinical Center in Bethesda, Md., or at Saint Elizabeths Hospital, Washington, D.C.

Chronic schizophrenics: a total of 30 male chronic schizophrenic patients who were housed on a special NIMH research ward at Saint Elizabeths Hospital. Eleven were free from all drugs for at least 30 days; 19 were taking phenothiazines equivalent to less than 400 mg. of chlorpromazine per day.

Acute schizophrenics: a total of ten patients who were psychotic at the time of blood drawing, were demonstrably ill for less than six months, and were free of drugs for at least two weeks. They were studied on a research ward at the Clinical Center or at the emergency room of Saint Elizabeths Hospital.

All patients were diagnosed according to the criteria of APA's *Diagnostic and Statistical Manual of Mental Disorders*, second edition (7).

TRYPTAMINE-METHYLATING ENZYME IN RED BLOOD CELLS (SERIES 1)

Method

Because several enzymes of importance to brain function have recently been described in the red blood cells, this was the first blood component we examined (see appendix 1).

Results

All samples in this and the following series were run without the experimenter's knowing whether they came from patients or controls. There was no difference in enzyme activity in red blood cells among 20 normal adults, 22 chronic schizophrenics, ten acute schizophrenics (drug-free for at least 14 days), and five patients with psychotic affective disorders (see table 1). There was no difference in enzyme activity for the two groups of schizophrenic patients.

Read at a New Research session of the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the National Institute of Mental Health, where Dr. Wyatt is Acting Chief, Laboratory of Clinical Psychopharmacology, Saint Elizabeths Hospital, Washington, D.C. 20032, Dr. Saavedra is NIH International Postdoctoral Fellow, and Dr. Axelrod is Chief of the Section on Pharmacology, Laboratory of Clinical Science.

TABLE 1
Comparison of Methylating Enzyme Activity in Red Blood Cells of Normal and Patient Groups

Group	Number of Subjects	Counts per Minute/5 μl. of Whole Blood Mean ± S.D.
Normal subjects	20	620 ± 43
Chronic schizophrenics		
Total	22	561 ± 33
Drug-free	11	600 ± 25
Acute schizophrenics	10	680 ± 40
Psychotic depressives	5	611 ± 39

ENZYMATIC METHYLATION OF N-MONOMETHYLTRYPTAMINE IN PLATELETS (SERIES 2, EXPERIMENT 1)

Method

Platelets were separated from other blood components by differential centrifugation (see appendix 2). Figure 1 demonstrates the enzyme activity in platelets for different protein concentrations, using monomethyltryptamine and ^{14}C S-adenosyl-methionine (SAM) as substrates. The radioactive extractable product formation was linear for high protein concentrations, but at low protein concentrations the product increased inversely with the amount of protein. This suggested the presence of a dilutable inhibitor, which had to be taken into consideration, since the platelet-protein concentrations used in the assay varied from subject to subject.

Identification of the enzymatic product was attempted after drying the samples both under nitrogen and in the vacuum desiccator. At least five different solvent systems were used. Figure 2 shows results typical of these systems. Only about 25 percent of the total radioactive product could be identified as authentic DMT, with a high percentage (50 percent) of the unknown material migrating with the front. Because of the failure to fully identify the product of the enzyme, the enzyme activity was expressed in total counts per minute (cpm.) per milligram of protein.

The protein determinations were done by the method of Lowry and associates (8). Five assays from the same person, with blood drawn over a five-month period, produced a maximum range of 22 percent around the mean.

Results

The results are summarized in table 2 and figure 3. Among the normal subjects, men and women had the same enzyme activity in platelets. There was no significant correlation with age, which ranged from 19 to 60 years. The mean value for the alcoholic patients was not statistically different from that of the normal group.

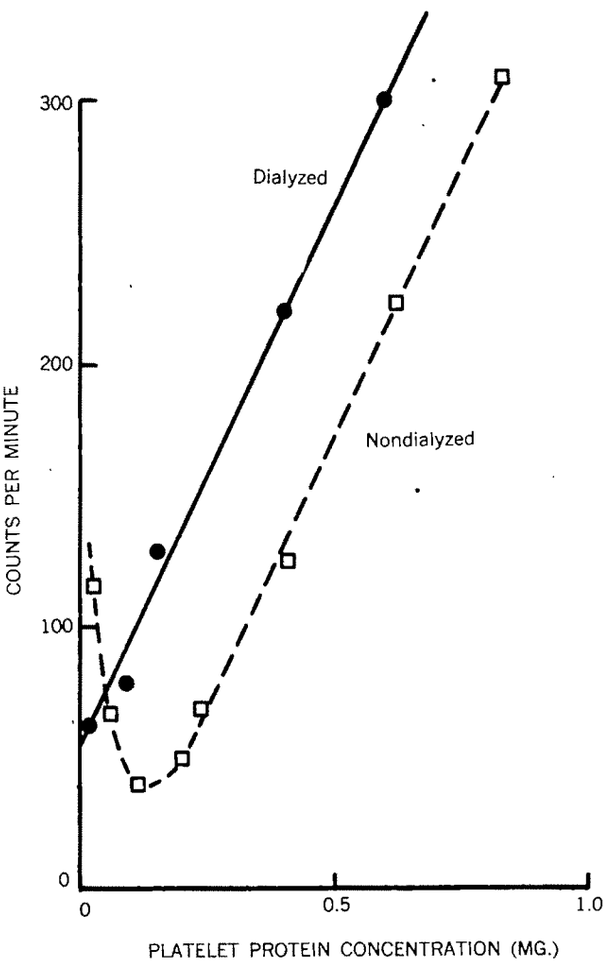
Using a two-tailed t test, it was found that the mean enzyme activity for the psychotic depressives was significantly elevated ($p < .01$) above that of the normal group. The mean activity of the drug-free chronic schizophrenics was also significantly higher ($p < .01$) than that of normal controls, while the group of chronic schizophrenics taking phenothiazines had a mean that was not statistically different from that of the "nonmedicated" group. The combined mean cpm. for the 30 schizophrenic patients was significantly higher ($p < .001$) than that of the normal group. The mean platelet enzyme activity of the group of acute schizophrenics was significantly higher ($p < .01$) than that of the normal group.

N-METHYLATION OF TRYPTAMINE IN DIALYZED PLATELETS (SERIES 2, EXPERIMENT 2)

Method

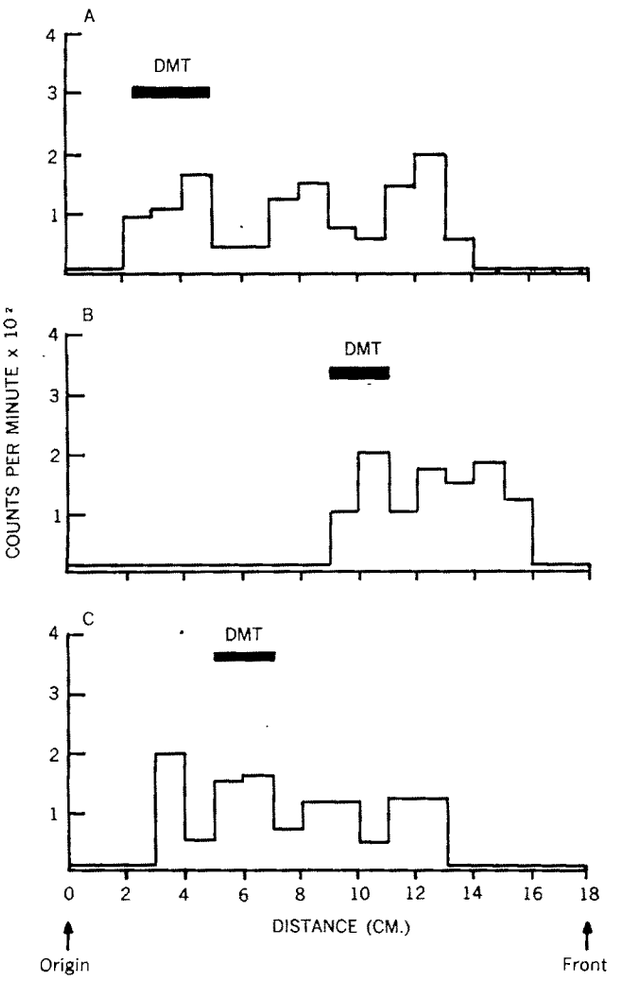
Concomitantly with the above studies, we found that

FIGURE 1
*Protein Concentrations Versus Product Formation for Dialyzed and Nondialyzed Platelets**



*Dialysis increases enzyme activity and also prevents the J-shaped curve that occurred in the nondialyzed sample; the curve is probably due to the presence of a dilutable inhibitor.

FIGURE 2
Identification of the Product in Nondialyzed Platelets in Three Solvent Systems Using N-monomethyltryptamine as the Substrate*



*A = toluene : acetic acid : ethyl acetate : water (80:40:20:5); B = isopropanol : ammonium hydroxide (ten percent) : water (200:10:20); C = N-butanol : acetic acid : water (12:3:5). Using these and other solvent systems, only about 25 percent of the total radioactive product was isographic with authentic DMT (indicated by the black bar).

TABLE 2
Comparison of Methylating Enzyme Activity in Nondialyzed Platelets of Normal and Patient Groups

Group	Number of Subjects	Counts per Minute per mg. of Protein Mean ± S.D.
Normal subjects		
Men	32	125 ± 8
Women	17	126 ± 6
Combined	49	126 ± 7
Alcoholics	10	104 ± 13
Psychotic depressives	13	190 ± 23*
Chronic schizophrenics		
Drug-free	11	217 ± 22*
Taking phenothiazines	19	182 ± 19*
Combined	30	199 ± 15**
Acute schizophrenics	5	239 ± 42*

*$p < .01$ (two-tailed t test), compared with normal subjects.
**$p < .001$ (two-tailed t test), compared with normal subjects.

the activity of methylating enzymes in platelets and human brain could be greatly increased by dialysis. In view of this finding, it appeared possible that the above difference in platelet enzyme activity could be due to the difference in a dialyzable inhibitory factor rather than to enzyme activity per se. Platelets were obtained and assayed in the same manner as that in experiment 1. In addition, sonicated platelet material in 0.5 ml. of 0.01 M TRIS buffer (pH 8.6) was dialyzed against a similar buffer for 18 hours with three changes of buffer. As can be seen in figure 1, this had two effects: it increased the enzyme activity per milligram of platelet protein and prevented the dilution effect seen at low protein concentrations in nondialyzed platelets (in practice, assays with protein concentrations of less than 0.2 mg. occasionally demonstrated this effect and were discarded prior to the breaking of the patient identification code).

The radioactive product was identified using three solvent systems on thin-layer chromatography (figure 4). The chromatographic spot isographic with authentic DMT represented 70 to 80 percent of the total radioactivity. The isographic spot was scraped from the chromatographic plate and eluted with 0.5 ml. of methanol and co-crystallized with cold DMT for four recrystallizations (9). There was constant specific activity through the four recrystallizations. The Michaelis constants (K_ms) for tryptamine, N-methyltryptamine, and SAM did not change appreciably with dialysis.

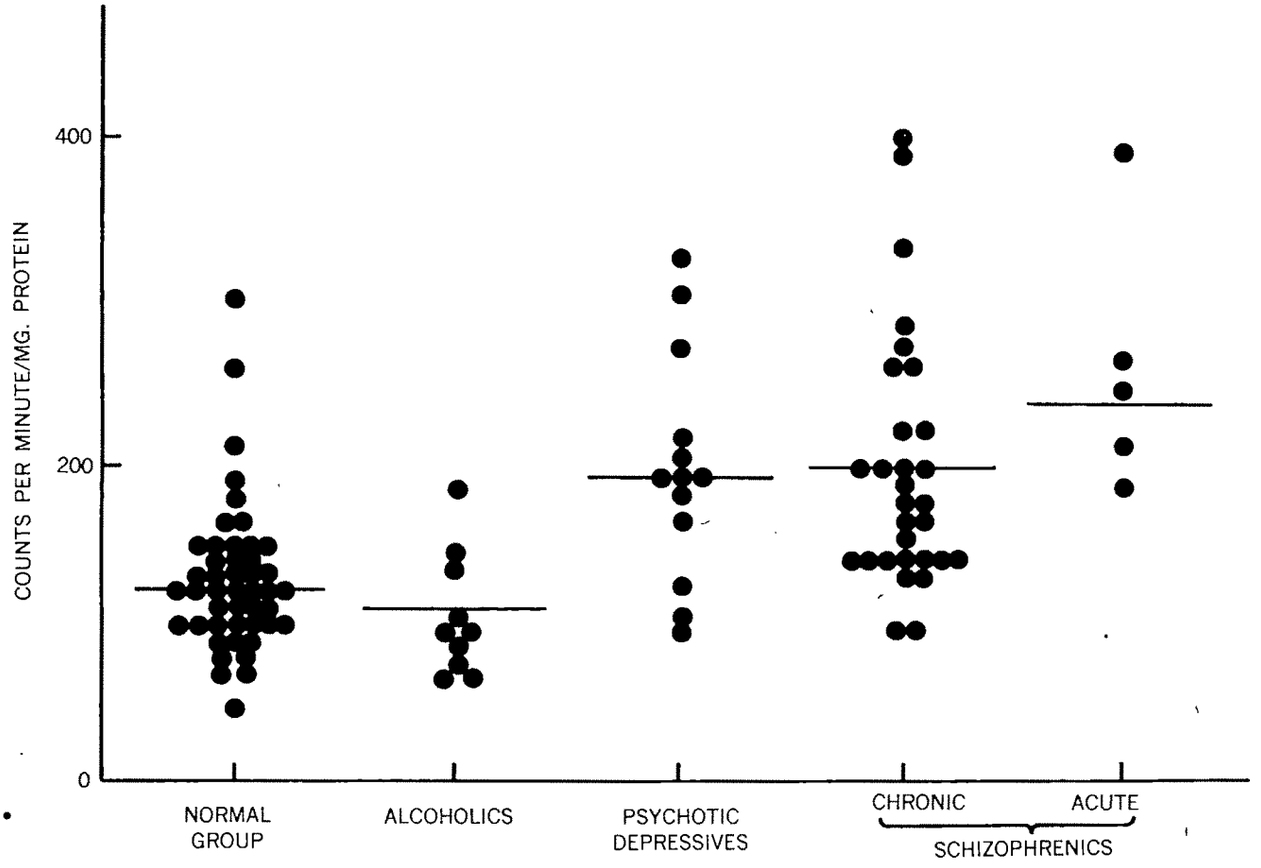
Results

The results are summarized in table 3 and figure 5. Among normal subjects, the N-methyltransferase activity in dialyzed platelets was 50 to 100 percent higher than in nondialyzed platelets ($p < .001$). There was no statistical difference in activity between men and women and there was no significant correlation of enzyme activity with age. Five samples taken from the same subject over a two-month period produced a maximum range of 52 percent around the mean.

The mean value for 11 chronic alcoholics was higher ($p < .02$) than the nondialyzed values from the same subjects but was not statistically different from the mean for dialyzed samples from normal subjects. The same was true for nine psychotic depressives, whose mean activity was significantly higher than their nondialyzed values but not different from the mean for dialyzed samples from normal subjects.

The mean level of activity for eight drug-free chronic schizophrenics was not significantly different from that for nine chronic schizophrenics receiving phenothiazines. However, their combined mean activity was statistically higher ($p < .01$) than that in the nondialyzed

FIGURE 3
*Enzyme Activity in Nondialyzed Platelets**



*Using a two-tailed t test for comparison with the normal group, there were significant differences for the psychotic depressives ($p<.01$), chronic schizophrenics ($p<.001$), and acute schizophrenics ($p<.01$).

samples from chronic schizophrenic patients. It was barely higher ($p < .05$) than the values found in dialyzed samples from normal subjects. If the highest single value from the schizophrenic patients was dropped, the difference was not statistically significant. Also, the nonparametric Mann-Whitney U test did not demonstrate this difference (10). Ten samples from acute schizophrenics had a mean value that was not different from that of the nondialyzed samples from acute schizophrenics or from that of dialyzed samples from the normal subjects.

N-METHYLATION ACTIVITY IN PLASMA (SERIES 3)

Method

Platelet-free plasma was obtained from the supernate of the platelet preparation. The assay was run identically to that in series 2, experiment 1, except that 200 μl. of plasma instead of the platelet preparation was added to the incubation mixture to make up a volume of 450 μl. On thin-layer chromatography, the product was found to be isographic with authentic DMT.

Results

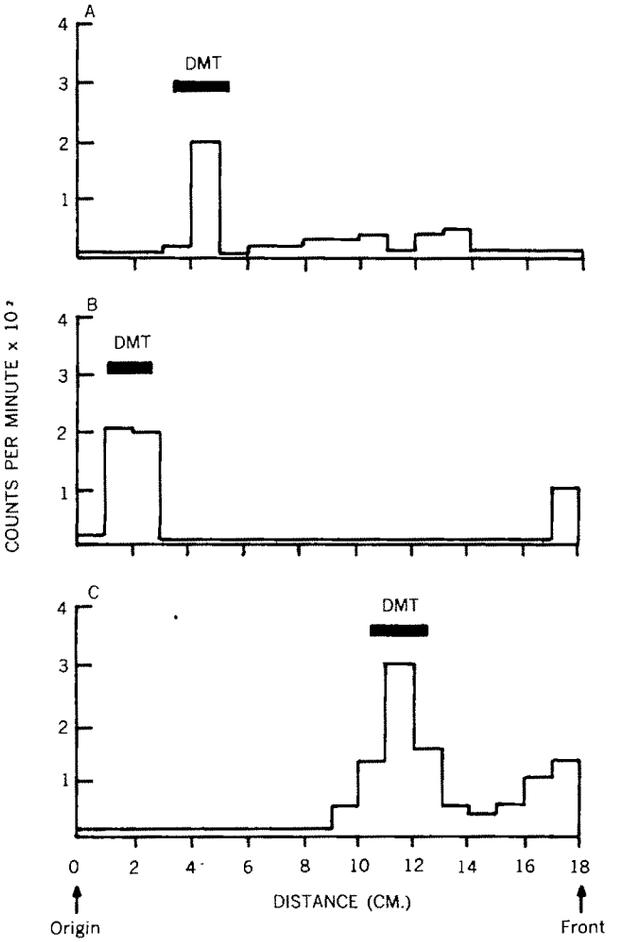
As shown in table 4, the activity for ten acute male schizophrenics (drug-free for 14 or more days) was not significantly different from the extractable product of activity for ten age-matched (age = 20 ± 4 years) normal male subjects.

DISCUSSION

There is enzyme activity in human red blood cells, plasma, and platelets that is capable of converting tryptamine to monomethyltryptamine and monomethyltryptamine to DMT. This activity is present in a number of mammalian species, including the primitive opossum. The level of activity, however, for all three blood components is very low (less than one percent of the total radioactivity was recovered). Because of the

FIGURE 4

Identification of the Product in Dialyzed Platelets in Three Solvent Systems Using N-monomethyltryptamine as the Substrate*



*A = N-butanol : acetic acid : water (12:3:5); B = toluene : acetic acid : ethyl acetate : water (80:40:20:5); C = isopropanol : ammonium hydroxide (ten percent) : water (200:10:20). Using these solvent systems, 60 to 80 percent of the total radioactive product was isographic with authentic DMT (indicated by the black bar).

TABLE 3

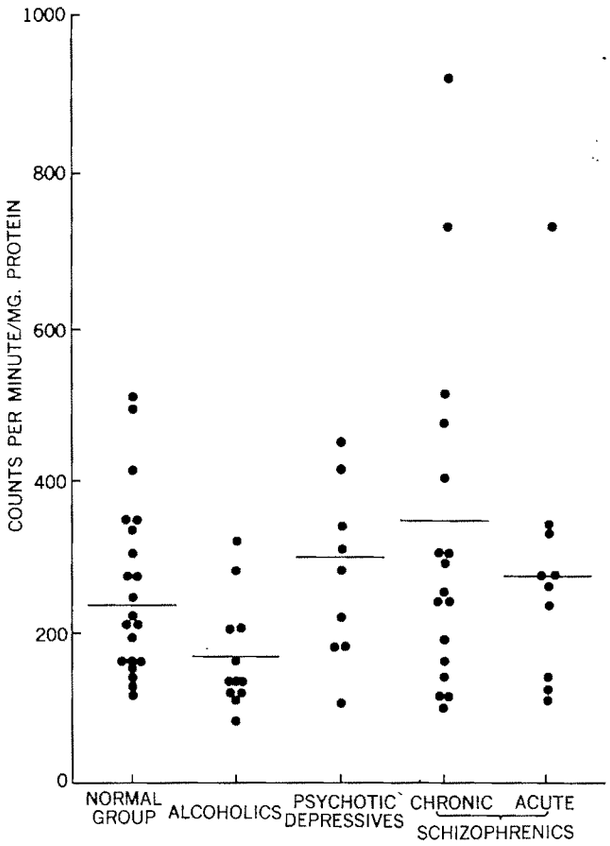
Comparison of Methylating Enzyme Activity in Dialyzed Platelets of Normal and Patient Groups

Group	Number of Subjects	Counts per Minute per mg. of Protein Mean ± S.D.
Normal subjects		
Men	15	220 ± 27
Women	6	282 ± 33
Combined	21	238 ± 22
Alcoholics	11	171 ± 22
Psychotic depressives	9	300 ± 42
Chronic schizophrenics		
Drug-free	8	327 ± 86
Taking phenothiazines	9	364 ± 64
Combined	17	347 ± 51*
Acute schizophrenics	10	276 ± 57

*$p < .05$ (two-tailed t test), compared with normal subjects.

FIGURE 5

*Enzyme Activity in Dialyzed Platelets**



*The chronic schizophrenic group had a significantly higher ($p < .05$) value than the normal subjects; this difference disappeared when the highest patient value was omitted or the nonparametric Mann-Whitney U test was used.

platelets' relatively higher activity (on a milligram of protein basis) and physiologic substrate affinities (K_ms) they seemed to provide the best approach to the development of a sensitive assay. The product of the nondialyzed platelets was only partially identified on the thin-layer chromatography. The reasons for this are not clear. One possibility is that DMT is rapidly broken down by a substance present in the nondialyzed platelets but not in the dialyzed samples. Conceivably, this substance could account for the differences between the dialyzed and nondialyzed platelet values.

Assays of enzyme activity of both red blood cells and plasma showed no difference between psychotic patients and normal subjects. Thus, while allowance must be made for possibly different patient populations and meth-

TABLE 4
Comparison of Methylating Enzyme Activity in Plasma of Normal Subjects and Acute Schizophrenics

Group	Number of Subjects	Counts per Minute per 200 μl. of Plasma Mean ± S.D.
Normal subjects	10	75 ± 17
Acute schizophrenics	10	63 ± 26

odology, the radioassay described here was unable to confirm the report of Narasimhachari and associates (11) of increased N-methyltransferase activity in the sera of schizophrenic patients.

The results of the clinical assay with the platelets must be given careful consideration. The samples of nondialyzed platelets from the acute schizophrenics, chronic schizophrenics, and psychotic depressives had higher levels of activity than normal subjects and chronic alcoholics. The chronic alcoholics were included to test whether hospitalization itself was responsible for the differences. It apparently was not. One factor that was not controlled for was the possible influence of stress, which is probably greater in the psychotic groups than in the normal subjects or alcoholics. The fact that the enzyme activity was elevated in both depressed and schizophrenic patients increases the likelihood that the abnormality is nonspecific.

It was of particular interest that the phenothiazines (equivalent to 400 mg. of chlorpromazine or less) had a relatively small effect on the enzyme activity. If anything, it tended to decrease the activity and probably cannot be used to explain the differences between the chronic schizophrenic groups for the nondialyzed platelets.

The difference in enzyme activity between psychotic and nonpsychotic subjects was greatly diminished by dialysis. It therefore appears that the difference in enzyme activity between psychotic and normal subjects is due to the presence of a dialyzable inhibitor (or a substance capable of metabolizing DMT) in normal subjects and not due to a quantitative difference in the enzyme. The identity of this inhibitor is not known.

From the red blood cell, plasma, and platelet data, it appears that there is no evidence for an enzymatic difference between psychotics and nonpsychotics for the enzyme capable of forming DMT. The question of whether there is an inhibitor (or substance capable of metabolizing DMT) in the platelets has not been resolved. If there is such a substance, it is decreased in depressed as well as schizophrenic patients and is not specific to one diagnostic group. Such a substance could be related to the recent finding of low platelet monoamine oxidase in some depressed patients and schizophrenics (12, 13).

REFERENCES

1. Osmond H, Smithies JR: Schizophrenia: a new approach. J Ment Sci 98:309–315, 1952
2. Wyatt RJ, Termini B, Davis JM: Biochemical and sleep studies of schizophrenia: a review of the literature—1960–1970, parts I and II. Schizophrenia Bulletin 4:10–66, 1972
3. Szara S: Dimethyltryptamine: its metabolism in man; the relation of its psychotic effect to serotonin metabolism. Experientia 12:441–442, 1956
4. Axelrod J: Enzymatic formation of psychotomimetic metabolites from normally occurring compounds. Science 134:343, 1961
5. Mandell AJ, Morgan M: Indole(ethyl)amine N-methyltransferase in human brain. Nature 230:85–87, 1971
6. Saavedra JM, Axelrod J: Psychotomimetic N-methylated tryptamines: formation in brain in vivo and in vitro. Science 172:1365–1366, 1972
7. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968
8. Lowry OH, Rosebrough NJ, Farr AL, et al: Protein measurement with the Folin phenol reagent. J Biol Chem 193:265–275, 1951
9. Walker RW, Ahm HS, Mandel LR, et al: Identification of N, N-dimethyltryptamine as the product of an in vitro enzymatic methylation. Anal Chem (in press)
10. Siegel S: Nonparametric Statistics for the Behavioral Sciences. New York, McGraw-Hill Book Co, 1956
11. Narasimhachari N, Plaut JM, Himwich HE: Indolethylamine-N-methyltransferase in serum samples of schizophrenics and normal controls. Life Science 11:221–227, 1972
12. Murphy D, Weis R: Reduced monoamine oxidase activity in blood platelets from bipolar depressed patients. Am J Psychiatry 128:1351–1357, 1972
13. Murphy D, Wyatt RJ: Reduced monoamine oxidase activity in blood platelets from schizophrenic patients. Nature 238:225–226, 1972

APPENDIX 1

Details of Methods in Series 1

For each patient, 30 ml. of blood was collected in plastic syringes and transferred into tubes containing 0.01 mg. of sodium heparin USP (Hynson, Westcott, and Dunning). The red blood cells were separated by centrifuging at 125G for ten minutes at 4C, the supernate was discarded, and the red blood cells were washed twice in saline solution. The red blood cells were then centrifuged at 12,000G for ten minutes at 4C and lysed by freeze-thawing twice.

The methylating activity was examined by incubation of 50 μl. of a mixture of one part lysed and packed red blood cells (equivalent to 5 μl. of whole blood) to four parts of 0.01 M sodium phosphate buffer (pH 7.9), 5 mμmoles of S-adenosyl-l-[methyl-^{14}C] methionine (SAM) with a specific activity of 54.6 millicuries/mmole (New England Nuclear), and 200 μg. of tryptamine (Aldrich). This mixture was made up to 260 μl. with the sodium phosphate buffer. The blank consisted of the same substances with tryptamine omitted. The reaction was stopped after four hours of incubation at 37C with 0.6 ml. of 0.5 M sodium borate buffer (pH 10). The radioactive product was extracted into 6 ml. of 97 percent toluene and three percent isoamyl alcohol; this solvent mixture extracts any methylated tryptamines.

The organic phase was separated by centrifugation at 5,000G for five minutes; 5 ml. of the organic phase was transferred to a counting vial and dried in a ventilated oven at 80C for eight hours to remove the volatile ^{14}C methanol produced by a methanol-forming enzyme. Using this procedure, about 6 μμmoles of radioactive product was formed. When the incubation mixture was preheated for ten minutes at 80C, no radioactive product was formed.

Other conditions tried but not found to alter activity were the addition of dithiothreitol (Cleland's reagent) in five concentrations ranging from 7.4 x 10^{-3}M to 4.6 x 10^{-5}M, pargyline (2.6 x 10^{-3}M), disodium ethylenediamine tetra acetate, calcium chloride, ferric sulfate, manganese sulfate, cupric sulfate, magnesium sulfate in four concentrations ranging from 3.7 x 10^{-3}M to 3.7 x 10^{-6}M, and dialysis. TRIS and phosphate buffers of 0.2 and 0.01 M with pHs from 7.0 to 8.6 were tested. The optimal pH was found to be 7.9 in a 0.01 M phosphate buffer.

Using serotonin creatinine sulfate as a substrate, the experimental to blank (no substrate) ratio could not be increased above 3:2 and was felt to be unreliable. The ratio of radioactive product extracted in the presence and absence of tryptamine was at least 4:1. The higher ratio for tryptamine than for serotonin indicated that tryptamine provided a more sensitive assay.

The Michaelis constant (K_m) of the crude enzyme preparation was about 10^{-2}M for tryptamine and 9 x 10^{-3}M for N-monomethyltryptamine. The K_m of SAM for both substrates was about 2.6 x 10^{-5}M. Since the K_m value indicates the enzyme's affinity for its substrate, the high K_ms for tryptamine and monomethyltryptamine indicate that an extremely high concentration of these substrates would be necessary to produce any significant product. Very high concentrations of tryptamine (58 mM) inhibited the reaction. Five samples taken from the same person over a two-month period were within 20 percent of the mean.

The identification of the ^{14}C-methylated tryptamine was done by thin-layer chromatography on Eastman chromatogram sheets of silica gel, 100 microns in thickness. All sheets were activated by heating for 30 minutes at 90C immediately before using. Seventy-five percent of the radioactive product was isographic to authentic N-monomethyltryptamine and 25 percent was isographic to authentic DMT.

The relative enzyme activity of four species, as compared with man (100 percent), was: Virginia opossum = 77 percent, domestic cat = 61 percent, guinea pig = 42 percent, and white laboratory rat = ten percent. The relative activity per milligram of protein for platelets, red blood cells, and plasma was 100 percent:22 percent:six percent.

APPENDIX 2

Details of Methods in Series 2

To separate platelets from other blood components, 16 ml. of whole blood was collected in 2 ml. of water containing 16 mg. of citric acid, 49 mg. of sodium citrate, and 41 mg. of dextrose (ACD solution A) in a glass Vacutainer tube (Becton-Dickinson). We were able to store the blood in ice for at least five hours without any change in the enzyme activity. The blood was centrifuged in a refrigerated instrument at 170G for ten minutes. The platelet-rich plasma supernatant was removed, provided that no visible red color from the red blood cells was present. This procedure was repeated at 380G and 680G.

The platelet-rich plasma was centrifuged at 3,020G for ten minutes and the platelet-poor plasma was poured off. The platelet pellet was washed with 2 ml. of saline solution. We were able to store the pellet for as long as 30 days at –20C without measurable loss of activity.

For the enzyme assay, 0.5 ml. of 0.01 M TRIS buffer (pH 8.6) was added to the pellet and the sample was sonicated on a Branson S-125 instrument at 5 amps (DC) for 15 seconds. Microscopic examination (x 1000) of oil immersion indicated complete lysis of the platelets. The incubation mixture used contained 0.2 to 0.5 mg. of platelet protein, 25 mμmoles of ^{14}C SAM with a specific activity of 54 millicuries/mmole (New England Nuclear), and 200 μg. of N-monomethyltryptamine (Aldrich) diluted to 300 μl. with 0.01 M TRIS buffer (pH 8.6). The incubation mixture without the N-monomethyltryptamine served as a blank.

The samples were incubated for 90 minutes at 37C and the reaction was terminated by adding 1.2 ml. of 0.5 M sodium borate buffer (pH 10). The product was extracted from the aqueous phase into 3 ml. of 95 percent heptane and five percent isoamyl alcohol. This solvent gives the lowest blank value and extracts the product almost quantitatively. The organic phase was washed with 1.2 ml. of borate buffer. To reduce the blank, 2 ml. of the organic phase was evaporated under 15 cm. of mercury in a desiccator heated to 60C for 30 minutes. This eliminated the volatile ^{14}C methanol produced by the methanol-forming enzyme. The residue was taken up in 2 ml. of ethanol and 10 ml. of phosphor, and the radioactivity was measured in a Beckman Scintillation Counter with an internal standard to correct for quenching. This procedure produced a more sensitive assay by reducing the blank.

The extractable radioactive product formation was linear with an incubation time of up to three hours. The optimal pH for N-monomethyltryptamine was 8.6 in a TRIS buffer (0.01 M) and 7.9 in a phosphate buffer (0.01M). Though the phosphate buffer (pH 7.9) produced nine percent higher total extractable counts, the experimental to blank ratio was 7:1 for the TRIS buffer versus 6:1 for the phosphate buffer. The K_m for the unpurified enzyme was about 1.6 x 10^{-4}M for N-monomethyltryptamine and 1.7 x 10^{-5}M for SAM. The Km for tryptamine was about 9 x 10^{-4}M.

Is Psychiatry as Establishment an Effective Force?

BY MILTON H. MILLER, M.D., AND JAMES AUERBACH

At the completion of APA's two-year focus on "Alternatives to Violence," the authors assess this effort as it was pursued at the district branch level. They compare the different strategies (both unsuccessful) used by two hypothetical district branches and contrast them with a similar effort by a community organizer that, while it met with some success, had little influence with the holders of power in the community. The authors advance some recommendations for assessing the APA effort and learning from both successes and failures.

THE AMERICAN PSYCHIATRIC ASSOCIATION at its Dallas meeting completed a two-year period of working to find "Alternatives to Violence." A national commission was established, a number of regional committees were at work, essays were composed, and individual projects were undertaken. A number of psychiatrists undoubtedly traversed the complicated path experienced by those who leave their offices and become involved in helping to solve complex social problems. It is a pathway through the stages of initial exuberance and confidence, the construction of simplistically conceived, global, and unrealistic programs, followed by inevitable periods of self-confrontation after which the psychiatrist either withdraws entirely from the area or accepts a smaller, delineated project for continued personal endeavor.

Central to this self-confrontation is the question: "Can middle-aged, affluent, Establishment-oriented psychiatrists effect social change?" Or, conversely: "Are those who are well accepted and rewarded in a social system automatically excluded from the ranks of individuals with enough personal commitment to modify deeply set social behaviors?" This question is an important one since it is key not only for psychiatrists who seek Alternatives to Violence but also for many kinds of citizens who wish to make the agencies of society serve all the people.

In this paper we will review various patterns of pseudo-confrontation and ultimate withdrawal from the field of seeking Alternatives to Violence. For heuristic reasons, events that might have been observed within two hypothetical APA district branches will be described. In contrast, a brief description of a personally committed but essentially powerless (certainly underpaid) individual who works full-time toward nonviolent social change is offered. The conjecture drawn from our stories suggests that while psychiatry as Establishment could in theory be effective in seeking Alternatives to Violence, a genuine exercise of the profession's influence would in controversial matters constitute more risk taking than most professionals, and thus the profession, are willing and able to undertake.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Miller is Professor and Head, Department of Psychiatry, University of British Columbia, Vancouver, B.C. Mr. Auerbach is Psychiatric Specialist, Department of Psychiatry, University of Wisconsin, Madison, Wis.

HYPOTHETICAL EXAMPLES

Example 1. The president of District Branch A responded quickly to the announcement that the American Psychiatric Association was committed to a two-year involvement with Alternatives to Violence. He circularized the entire membership inviting their ideas and, within a two-month period, had appointed a state-wide task force numbering a dozen individuals. Before the end of the first year this task force, which had accomplished nothing, ceased to meet. The way this came about was as follows: The 12 psychiatrists chosen from the membership of the district branch came from five different cities and included professors from a medical school, staff members from state mental hospitals, and private practitioners of psychiatry, most of whom were involved in various community consultative roles. In all, three meetings were held. The first meeting was the most spirited; nine members were present. The third and final meeting was attended by only two committee members.

Although the first meeting was spirited, that spirit reflected chiefly the diverse political philosophies of the group, philosophies only vaguely modified by the fact that the men present (there was no woman on the task force) were all psychiatrists. The approaches suggested to the search for Alternatives to Violence varied in accordance with the politics of the participants.

Dr. X., a man active in district branch endeavors and a politically conservative person, suggested an attempt to discredit the radical movement in a nearby college in order to separate the "essentially decent majority" from the handful of "extremist agitators." He suggested the establishment of a group of mental health professionals who would make themselves available in times of crisis to wean away the good from the bad.

Dr. Y., a young medical school professor of liberal political persuasion, saw the problem as quite the reverse. He felt that violence involving students in one nearby college community was the direct result of American militarism in the Viet Nam war, which in turn offered the police an opportunity to express brutality. He favored the development of a group of professional observers to be mobilized in times of civil disturbance and who, wearing wide white armbands, would place themselves between students and the police in order to hold off the police if they should attempt to quiet the protest of the students. This professor also favored an immediate vote by the committee condemning the war, proposing an end to the draft, and sug-

gesting that all psychiatrists in the state refuse service to the draft board.

A third member of the commission, Dr. R., interrupted the essentially political discussions of Drs. X. and Y. in order to propose what he felt was a more psychological approach. He felt that the parent-child model of relationships was the best one for understanding violent protests and believed that the ambivalence and repressive yearnings of parents were often responsible for the acting-out behavior of younger adults. His theoretical position was transposed in part from the ideas of Johnson and Szurek (1). He felt that the violence of upper- and middle-class young people reflected the ambivalent attitudes of many of their successful parents. Conversely, the reported violence on the part of police was, in his opinion, a failure of the mechanism of reaction formation in response to their own aggressive feelings. He believed this failure occurred because of the frequent exposure to violence in the social class in which members of the police force had grown up. He suggested psychiatric descriptions of the emotional problems of violent people, articles and publications outlining these two main causes of violence, and public educational campaigns in the grade schools and high schools to teach that all people have violent tendencies but that these must be controlled effectively if society is to survive.

Dr. R.'s views were severely criticized by his professor colleagues as indicating a failure to understand the complexity of societal structure. They were also criticized by the more conservative Dr. X., who felt that the radicals who were causing all the trouble had been overlooked! These discussions continued for three hours during the first meeting and for two hours during the second meeting; by the time of the third meeting what had become clear was that there would not be a fourth meeting.

Example 2. In District Branch B the approach taken was less egalitarian in that one person was assigned responsibility for developing a program. However, at the end of a year, this approach was apparently no more fruitful than the approach taken in District A.

Dr. T.'s thinking had been greatly influenced by the work of Konrad Lorenz and by his reading of Erik Erikson's *Gandhi's Truth.* In the latter book Professor Erikson suggested that Gandhi, in his system for nonviolent action, had developed a ritualization of conflict analogous to that with which animals oppose one another without murderous or genocidal rage. Dr. T. felt a synthesis of these ideas with certain Sullivanian concepts offered much promise for a new approach to the problems of violence. He readily accepted the chairmanship of District Branch B's Committee on Alternatives to Violence and within a few days developed several news releases and wrote a position paper for approval by his colleagues. Dr. T. found acceptance and enthusiasm for his theoretical ideas and for the approaches that seemed naturally to follow in discussion with the residents-in-training whom he supervised. The program he proposed for the district branch included a series of interventions that he believed psychiatrists might teach to schoolteachers, ministers, police officers, etc.

However, Dr. T.'s theories and plans, vigorously presented though they were, sparked little interest among the membership of his district branch. Some members felt that Dr. T.'s effort was self-serving. Others thought his plans impractical. Mostly, however, his colleagues were simply too busy to be involved. It came to pass that Dr. T.'s effort was destined to remain an individual matter and not part of a group effort. Possibly contributory to Dr. T.'s inability to mobilize even a small amount of interest was the fact that this district branch was governed by its older members and they had grown very familiar with Dr. T.'s ideas—perhaps to a point where their enthusiasm had been extinguished. In District Branch B, there was no active planning to involve younger members or residents-in-training in district branch affairs, and the participation of such individuals was limited to attendance at occasional guest lectures.

In both District Branch A and B, while theoretical questions constituted part of the difficulty, other practical problems were of at least equal importance. Drs. X., Y., R., and T. and all of their colleagues were enormously busy men who were accustomed in their offices to being heard when they spoke. Struggling intellectually in an eclectic, open manner, accepting critique, seeking synthesis, acknowledging error, and the whole complicated matter of a scholarly debate over ideas were styles of communicating that were not easily transferred to a different setting. Furthermore, in the case of all the participants, their time was extremely valuable. In monetary terms, their time was worth $25 an hour. Indeed, in the case of one of them, professional expenses alone were estimated at $10 an hour. Arranging meetings was extremely difficult because of the necessity for cutting into the psychiatrists' other commitments, including private practice, and this necessitated evening and weekend meetings, which understandably diminished both the attendance and the commitment. And, as it became clear that a genuinely effective input to the search for Alternatives to Violence would be achieved only with difficulty, only over time, and possibly not at all, each participant weighed the priorities of patients, office overhead, leisure, time to read, travel, etc., against the task force assignment.

An additional problem was the doctors' concern about any statements or activities that might cause the public to prejudicially group together all psychiatrists as either radical or conservative, impractical or business-minded, etc. One reason for such a fear of public utterance was voiced by Dr. X., who said: "The town in which I live is very concerned about what students in the college are doing. It's a religious town and I have to be very careful not to defend radicals. Putting my name into the middle of a public controversy wouldn't be fair to my patients." Another psychiatrist was concerned lest complaints about the alleged brutal treatment of sexual criminals in the local prison lead to political reprisals in the form of a cut in appropriations to the local mental hospital. A third psychiatrist expressed concern that discussion of any controversial matters would fragment the district branch and lead to a weakened position for psychiatry among the other medical specialties. He cautioned that psychiatry's special place could best be ensured by sticking to medicine, to hospitals, to illness, and to well-defined consultative roles.

THE CONTRAST: MR. JIM S.

By contrast, consider the efforts of 24-year-old Mr. Jim S. This young man is a college graduate who works full-time as advocate and coordinator of a group of young people working for nonviolent social change. His

salary is relatively small. Through private foundations and personally solicited donations, he receives some $4,000 a year. His overhead is also low. His room rent is $80 a month and his personal expenses about $150 a month. Most of his helpers are volunteers. Some are young people (in or out of school); a few are older individuals with a long allegiance to various religious and other nonviolence movements. Jim travels light and can and does go anywhere, anytime, in order to attend and participate in meetings or special programs directed toward the peaceful resolution of conflict. Although he is a soft and gentle person, at this point in his life he is essentially fearless, believing sincerely that Gandhi was correct in saying that the only cause for fear is a love of possessions or power or the wish for popularity. Jim worries little about his image either with other young people—many of whom regard him as an "unrealistic idealist"—or with older adults, some of whom are put off by the length of his hair and casual dress.

Jim and his associates are involved with many interesting and potentially worthwhile undertakings. They are attempting to broaden the interest in "peace toys" in contrast to guns, cannons, toy soldiers, etc. They are developing weekend training groups to learn techniques for nonviolent action. Such a group, in cooperation with a state university, organized a nationally attended seminar on Alternatives to Violence. Jim has been in contact with many leaders in his community in order to discuss the problems of violence and nonviolence but at no time has he had a significant audience among any of the affluent, power-holding, governing individuals in the community in which he lives.

Jim and his associates are psychologically available for the work but their resources are small and they speak to a limited minority who in turn are largely without power in their society. And they have another problem. By and large, they don't speak the language of the middle-aged and older power holders in the community. To an extent, they lack familiarity with group process and the exercise of influence as it occurs among older, affluent, governing individuals. Further, Jim and his associates tend toward inaccurate global generalizations, positive and negative, regarding those in power, who are conceived of either as embodiments of greed and avarice or, conversely, as naïve, innocent individuals who, given a few more facts, would make the right decisions. "You've got to know the territory," admonishes Meredith Wilson in "The Music Man"; there is much about the folkways of the middle-aged and older leaders of government, industry, and education that is unknown territory to Jim and most of those who surround him.

By contrast, the psychiatric community in aggregate (like the business community, the medical community, the legal community, the educational community) has available a substantial reservoir of influence. For psychiatrists, that influence ranges from professional endeavors in what Halleck calls the "Politics of Therapy" (2) to that other kind of power which derives from personal affluence and a place among other respected individuals and groups within each community.

THE PARADOX

But the paradox for psychiatrists and all who are "established" is that there is no possibility of remaining unblemished when one uses one's position from within to change the nature, the attitudes, the folkways of the Establishment. For psychiatrists and no less for other doctors, teachers, and lawyers who would work in the interest of alternatives to violence, rehabilitation rather than brutalization of prisoners, understanding rather than the categorization of sexual nonconformists, etc., there is a double-bind conflict that seems inevitable: Many who are in the established group feel that one must love it or leave it. And for psychiatrists who have long struggled for acceptance for their patients and their profession, leaving the Establishment is a menacing threat indeed. At the same time, a reflective profession like psychiatry inevitably asks itself: "Why have affluence and influence unless you put it to good purpose?" And, beyond the special situation of psychiatry, events of the last several decades have made it abundantly clear that the peaceful corrections of violence, hoarding, or destructively self-seeking social tendencies will require much concerted personal and group commitment from those who occupy high positions in society. We have discovered that the greatest delusion in the world is the widespread belief that some other person or group of persons is taking care of things and has an appropriate plan for all problems in the final stages of development.

SOME RECOMMENDATIONS

It is too early to fully assess the effectiveness of the American Psychiatric Association's two-year focus upon Alternatives to Violence. Yet it is already clear that many forces work against mature psychiatrists playing effective social change roles. And it seems particularly clear that effective role taking will require long-term efforts, working-through processes, bridge building, skill acquisition, and communication development. In short, an effective, sudden professional response to a crisis circumstance in community or nation is probably impossible. Instead, the following proposals may reflect more strategic professional commitments.

1. The American Psychiatric Association, its district branches, and its membership need to assess the two-year effort in search of Alternatives to Violence and not allow this period to pass without an honest appraisal of what did and did not happen.

2. This assessment should be formalized and ultimately made available to the membership; more broadly, it should serve as a basis for discussion with other professional organizations. Our successful and promising efforts should be made known to others. Of equal importance, what might have occurred but did not needs to be delineated and the reasons for failure better understood. The American Psychiatric Association is committed to working for rapid, peaceful social growth and the en-

hancement of opportunity for a deeper psychological and social life for all people. However, the Association's ability to move from Assembly purpose to district branch action may well require strengthening.

3. Finally, the Association needs to look at the relative activity and inactivity of our professional members early in their careers. Many of the problems facing society have a substantial young person-older people dimension. It is unlikely that any organization that does not fully represent and utilize its own younger members can be fully effective.

REFERENCES

1. Johnson A, Szurek SA: The genesis of antisocial acting out in children and adults. Psychoanal Q 21:323–343, 1952
2. Halleck S: The Politics of Therapy. New York, Science House, 1971

Questions of the Month

Directions: Each of the questions or incomplete statements below is followed by four or five suggested answers or completions. Select the *one* that is BEST in each case.

Question 1 The segment of severely depressed patients who do not respond to imipramine (Tofranil), amitriptyline (Elavil), or phenelzine (Nardil)
- (A) should continue to receive increasing amounts until the medication is effective or side effects appear
- (B) should be evaluated for psychosurgery
- (C) respond to electroshock therapy in 50 percent of the cases

Question 2 Which of the following groups has the highest suicide rate?
- (A) Young, impulsive females
- (B) Divorced men over 40 with an alcohol problem
- (C) Chronic schizophrenics with low self-esteem
- (D) Unmarried men age 20 to 30 with a drug abuse problem

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 777 of this issue.)

A Proposed "Dangerous Sex Offender" Law

BY NATHAN T. SIDLEY, M.D., AND FRANCIS J. STOLARZ, J.D.

Sex offender laws and other forms of preventive detention designed to protect the public from dangerous individuals have been criticized because of their subjectivity. The authors propose legislation that would ensure against abuse of the laws by the following means: strict definitional criteria of the dangerous sex offender in terms of predictability, requirement of proof of dangerousness, and time-limited commitments. They feel that implementation of this kind of law will restrict those incarcerated to the truly dangerous offenders and will help avoid overinclusive commitments.

DESPITE THEIR UNIMPORTANCE compared to other criminals, people who commit sex crimes seem to attract more attention from legislatures than do most offenders. This is not surprising, of course, for sex itself is more interesting than most other areas of activity. Yet the excess of attention and interest has not always led to the most effective laws.

One facet of sex legislation pertains to what one might call "dangerous sex offenders." Thirty states and the District of Columbia have such laws. The general idea behind them is that there are individuals who are uncontrollably sexually dangerous, who present threats to the community, and who should be locked up and/or treated until they are "cured." In practice the effect of these special laws is that people who are considered to be sexually dangerous tend to be treated differently and more punitively than people who are equally or more dangerous in some other area of behavior.

It is particularly important to note that although their ostensible purpose is to protect the public, dangerous sex offender laws are not designed as public health laws. There is no clinical entity of "sex crime," nor is there an epidemiology of "sex crime." Legislatures have not called in public health specialists as consultants when drafting such laws. Furthermore, there are no known public health measures that are effective in lowering the general incidence of sex crimes.

These laws thus function so as to deal with *specific* cases. They tend to be enacted after the occurrence of specific crimes, such as the Raymond Ohlsen case in Massachusetts, in which a man with an aggressive pedophiliac history murdered two boys shortly after his release from prison. (This is, of course, another factor leading to ineffective legislation. Public fear runs high at such times, and a legislature is under pressure. In such circumstances even the little knowledge about sex crimes that is available is not always attended to. It is of interest that strong public reactions more often follow violent sex crimes against children than those against adults. Although this may be due to psychological reasons, nevertheless offenders who act violently against children tend to be the most dangerous sex offenders.) The law asks the question of the specific case, "Is this individual another Raymond Ohlsen?" If the answer is yes, the individual is committed.

The function of the statutes is thus to enable a decision to be made about cases at hand. If a violent sex crime is committed by a man of the street, there is no way that legal process can prevent it. If a violent sex crime is committed by a person previously involved in the legal process, the process must ask itself, "Could that crime have been prevented by holding the individual in custody (or treating him, etc.)?" Legal process ought not to miss the opportunity for crime prevention and protection of the community when the opportunity is at hand. Therefore, although legal process is not a public health facility, and although the amount of sex crime trauma prevented in this manner is a negligible fraction of the total amount, the small opportunity for prevention should be grasped.

In this situation legal process sets for itself an excessively high level of aspiration. The fundamental issue faced by legal decision makers and psychiatrists, who are invariably associated with these proceedings, is that of prediction, i.e., prediction of recidivism. Prediction of events involving human behavior is difficult in general, but it is especially difficult when those events are rare. Most difficult is the prediction of behavior under unspecifiable circumstances, particularly when only meager information concerning prior conditions is available.

Yet these are precisely the circumstances in which accurate predictions are demanded of psychiatrists and judges. For all but a few cases it is an impossible situation. It is bad enough that the public should set impossible standards for decision makers, but it is serious when, as sometimes happens, the decision makers themselves believe that they can perform the impossible. It is worse when they criticize themselves for not attaining the impossible, as in a situation in which someone previously examined and declared not to be dangerous subsequently commits a seriously injuring offense.

There is a way, however, in which a situation that is impossible to predict can be converted into a feasible one

Revised version of a paper read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Sidley is Director, Psychiatric Clinic, Fourth District Court, Woburn, Mass. 01801. Mr. Stolarz is Staff Attorney, Massachusetts Defenders Committee, Boston, Mass.

in which the predictor cannot be "wrong." That is, of course, to predict that an individual will commit a dangerous act, then to lock him up and prevent him from doing so ("preventive detention"), a good example of a self-fulfilling prophecy. And this is what is done. Decision makers become conservative and incarcerate individuals about whom they have doubt. Thus many individuals who would never commit a subsequent sex offense, let alone an injurious one, are erroneously locked up because of decision-making conservatism. This is an intolerable situation!

SOME FACTS

Detailed actuarial information necessary to make intelligent predictions about sex offenders' recidivism is presently unavailable, and the kind of information required to make accurate specific predictions about many individual cases will probably not be available in our lifetime. There is some trend information that is worth considering, though, for it helps a bit in dealing with cases.[1] The basic problem, however, is classification, and all classifications of sexual offenders suffer severely from lack of homogeneity within classes and from occasional multiple class membership for some individuals.

Considering primarily the age and sex of the victim and the presence or absence of force or threats is nevertheless useful, for it presents a framework that is of some help in prediction (1). We thus consider: 1) heterosexual *offenders* (who *have not* used force or threats) against children under age 12, minors under 16, and adults; 2) heterosexual aggressors (who *have* used force or threats) against children under 12, minors under 16, and adults; 3) homosexual *offenders* (homosexual aggressors are very rare); and 4) exhibitionists and peepers (who do not have any physical contact with the sexual object and can be grouped together).

The primary consideration for our purpose is this: With some exceptions, the major group that is of concern with respect to recidivism leading to sexual crimes of violence is that of heterosexual aggressors against children under 12. Sometimes other aggressors repeat, but usually they don't, while some peepers are not consummatory peepers but are instrumental peepers reconnoitering for a more serious crime, during which they injure a victim. Although individuals in the other classes may have criminal careers lasting for years, they seldom use any violence. It is well known that once ordinary pedophiles (heterosexual offenders against children under 12), homosexuals, and exhibitionists are detected, they rarely progress to more serious sex crimes. Indeed, ordinary pedophiles (no use of force or threats) tend mainly to be older offenders who approach little girls known to them and who often live in the same household; these offenders tend to be a moralistic, almost prudish group. The incidence of ordinary pedophilia is great, running to perhaps half a million offenses annually in the United States (2).

Note, however, that heterosexual aggressors against children are the most criminally recidivistic of any group, i.e., not merely sex offenders but all offenders. Most come from broken homes, many are of below-average intelligence, and most are heavy drinkers and are intoxicated when committing their offense. Their victims tend to be strangers, and they have little concern for the feelings or welfare of their victims.

The likelihood of recidivism for a first-time sexual offender is only about one in ten, for a second-time or subsequent sex offender it is about one in three, while one out of two second-time or subsequent sex offenders with other crimes on their record tend to be repeaters. Aggressors are more recidivistic than nonaggressors, while the likelihood of recidivism is negatively related to the age of the victim.

The greater the number of sex offenses on a person's record, the greater the variety, i.e., an offender does not necessarily stick to one type of offense.

The role of alcohol in sex offenses is truly impressive. In many—probably over half of the sex crimes involving aggression—the offender is an alcoholic or a heavy drinker, and he commits his offense while intoxicated. A high proportion of nonaggressive sex offenses, particularly pedophilia, also involve alcohol.

Perhaps the fundamental problem, though, despite knowledge of facts like these, is that sex offenders are not uniform and what is true for one member of a class is not true for others. Thus if it is known that 50 percent of a certain class of offenders are recidivists, that is not much help in trying to decide whether the person before us will recidivate or not. The sad situation is that we do not know much about prediction for those offenders. Even more disappointing is that prediction will probably always be quite limited in this area because of the fortuitous association of circumstances that lead to sex crimes, e.g., alcohol, the presence of a potential victim, the absence of others, etc.

PROPOSED LEGISLATION

There is no law that can improve the ability of psychiatrists to predict future sexual violence. However, the law can do something to ensure that only those most likely to commit dangerous sexual crimes will be subject to incarceration. We wish as much as possible to prevent the occurrence of injurious sex crimes on the part of those who are exposed to the control of legal process, and we also wish to strenuously protect the rights of those subject to preventive detention as dangerous sex offenders so as to avoid locking up the wrong people. No completely satisfactory balance point exists, but we believe that the legislation proposed herein provides a more useful balance point than most.

The most important aspect is the definition of, or the

[1] The facts subsequently presented have been abstracted and rounded out to very simple figures, because there is variation among different sources and because there seems to be no practical legal benefit in being more precise.

criteria to be fulfilled before a person can be regarded as, a dangerous sex offender. First, in his past history he must have committed a sexual offense in which his victim was physically injured. Second, the person making predictions about the offender's future behavior must be able to demonstrate convincingly (i.e., beyond a reasonable doubt) that the offender will, within a period of one year, unless he is incarcerated or treated, commit a sexual offense that will result in physical injury to his victim. These criteria are strict, but there are offenders who meet them.

Other provisions of the proposed law are as follows.

Only those individuals who are *convicted* of one of various sexual felonies, such as rape [(3) Model Penal Code 213, 1 (a) (d)], gross sexual imposition [(3) Model Penal Code 213, 1 (2) (a) (b)], deviate sexual intercourse by force or imposition [(3) Model Penal Code 213.2 (1) (a) (d), 213.2 (a)], corruption of minors and seduction [(3) Model Penal Code 213.3 (1) (a)], or sexual assault [(3) Model Penal Code 213.3 4 (1) (4) (6)], or of the attempt to commit any of the foregoing crimes would be eligible for processing as dangerous sex offenders.

A commitment as a dangerous sex offender would require a hearing in which the defendant would be entitled to a jury, legal counsel, subpoena power for witnesses, independent psychiatric examinations, and any other rights held by those who are defendants in a criminal trial. Such a hearing would only be held if a majority of the examining psychiatrists clearly felt that the individual was a dangerous sex offender. If an examination or hearing indicated that the individual was not a dangerous sex offender, then ordinary criminal disposition of his case would be undertaken.

A treatment center would be established and maintained by the state agency responsible for mental health rather than by the agency responsible for prisons. The superintendent would be responsible for security but would be encouraged to use outpatient rather than inpatient facilities when feasible. He would recommend appropriately to the court when he felt that an individual was no longer a dangerous sex offender.

A person would be committed as a dangerous sex offender for an indefinite length of time not to exceed the maximum period of penalty for the offense of which he was convicted. If the individual were still regarded as acutely dangerous at the end of that time, he would be processed under the laws of the state governing commitment of the dangerously mentally ill. The individual would be entitled to reexamination yearly. No psychotherapist treating the individual would participate in the examination process without the individual's permission.

Any individual might volunteer for treatment in the treatment center.

Finally, the agency in charge of administration of these statutes would be authorized to budget for research up to ten percent of the total amount allocated for their implementation.

With the exception of the criterion and budget sections, the other provisions of this proposal are found in the laws of one jurisdiction or another. Few jurisdictions provide the safeguards of a criminal proceeding, however. The first provision is the most critical one, for it places strict definitional criteria on the meaning of dangerous sex offender. These criteria are highly circumscribing, but there are offenders who meet them. An example would be a heterosexual aggressor who commits multiple crimes against children, who does so while intoxicated, who is a chronic alcoholic, who has a long criminal career, who has no insight, etc.

It is hoped that the effect of this legislation would be to protect more effectively the rights of those facing the possibility of long-term commitment as dangerous sexual offenders by regarding the proceedings as analogous to criminal proceedings rather than civil proceedings as they are now. Further, it is expected that the number of those inappropriately committed to treatment centers for dangerous sex offenders would be decreased without significantly exposing the public to a greater danger from injurious sex crimes than now exists. If these goals are accomplished, society will have a more just and more effective mechanism for dealing with these troublesome cases. We believe that this legislation will be a step toward this end.

DISCUSSION

The suggestions herein represent one manner of dealing with the problem of overcommitment of those alleged to be dangerous sex offenders. Other possible approaches include outright repeal of such laws, commitment of these offenders to mental hospitals, or the expansion of treatment facilities in prisons.

Repeal has appeal. Because of the almost unavoidable potential for abuse of any preventive detention law, such laws are to be feared. However, repeal is not always possible; neither, for that matter, is reform. This proposal represents an attempt to minimize abuse by providing strict criteria and full rights for those under consideration as dangerous sex offenders, yet to provide for some measure of protection of the public and to provide psychiatric treatment rather than criminal punishment for these offenders. As noted earlier, the proposal represents a balance point, a point that we hope can be attained in the real world, maintained with some vigilance, and defended as a reasonable effort to cope with one small aspect of the problem of destructive violence.

Perhaps our most questionable proposal is the notion of a separate institution for dangerous sex offenders. Merely providing separate facilities encourages institutional conservatism, empire building, and abuse. A point perhaps in favor of placing dangerous sex offenders in mental hospitals is that they are likely to be released sooner than if they were in special institutions, if for no other reason than they are not welcome patients at psychiatric hospitals because they are different from most ordinary mental hospital patients. Yet their very difference makes whatever treatment can be given to them more difficult in a state hospital. For those few truly

dangerous people who are susceptible to change by treatment, confinement in a separate unit in a state hospital may be feasible. Chronic, untreatable, psychotic or organically disturbed dangerous sex offenders are suitable candidates for a mental hospital ward for chronic patients.

Finally, the same thing must be said about handling the dangerous in general as for handling the sexually dangerous in jurisdictions where there are no special laws for dangerous sex offenders. Such special laws should be strongly discouraged. Like most efforts to attain desirable goals with inadequate methods, in the long run they tend to do more harm than good.

REFERENCES

1. Gebhard PH, Gagnon JH, Pomeroy WV, et al: Sex Offenders, An Analysis of Types. New York, Harper & Row, 1965
2. Gagnon JH, Simon W: Sexual Encounters Between Adults and Children, SIECUS Study Guide No 11. New York, Sex Information and Education Council of the US, 1970
3. American Law Institute: Model Penal Code. Philadelphia, American Law Institute, 1962

Participation in the 1974 Annual Meeting May 6–10, Detroit, Michigan

A form for proposed contributions for APA's 1974 annual meeting was sent to all members in June. An abstract form was provided for those who wish to present a scientific paper, organize a special session or panel, or request the inclusion of a videotape or film. Another form was provided for those who wish to participate as officers of sessions or discussants of papers.

Interested members are urged to return the forms to the Office of the Chairman of the Program Committee, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009, as soon as possible. Persons who are not members of APA who wish to participate in the annual meeting may obtain the appropriate forms from the Office of the Chairman of the Program Committee. The final deadline for receipt of the completed forms is September 21, 1973.

Information on submitting papers for consideration for the New Research sessions will be made available at a later time.

Psychiatry with the Aborigines of West Malaysia

BY J. DAVID KINZIE, M.D., AND J. MALCOLM BOLTON, D.T.M.

The authors report on a year's experience with psychiatric patients from aborigine tribes in West Malaysia. Of the 20 cases seen, all but one were psychotic and 16 were also classified as schizophrenic. Withdrawal and running away were common symptom patterns. Only one patient came from a deep jungle area; the others were from fringe areas where sociocultural disruption was more evident. Because of a good preexisting medical service, these patients were easily managed in a hospital that emphasized their own culture. Follow-up in the jungle or villages by aborigine staff members and the use of long-acting injectable phenothiazines resulted in continued improvement of the patients.

THIS PAPER describes a year's experiences with West Malaysian aborigine psychiatric patients. The aborigines of West Malaysia (Malay peninsula) are a materially primitive, usually illiterate group of people who tend to populate the very remote interior jungle areas in that region. Because of the remoteness of their cultures, the types of illnesses they show and how these are presented at a medical clinic are of interest to modern psychiatry. In addition, from a cross-cultural standpoint, it is important to determine how diagnoses are made when the culture is so vastly different from a modern Western one. A final problem is adjusting treatment so that it can be accepted in a manner consistent with the culture and the patients involved.

This paper will report on 20 patients who were referred to a psychiatrist for evaluation between September 1970 and September 1971. One author (J.D.K.) was at the time of this project the attending psychiatrist for the Department of Aborigines and visiting lecturer, Department of Psychological Medicine, University of Malaya; he had previously worked for 16 months as a medical officer at an aborigine hospital. The second author (J.M.B.) has been medical director of the aborigine hospital for 16 years.

ETHNIC GROUPS AND MEDICAL PRACTICES

The aborigines (Orang Asli) are a heterogeneous group of peoples with diverse languages, racial origins, and cultural beliefs who live primarily in the jungle areas but sometimes populate the lowland swamps. A few live near the oceans. The relative isolation and predominantly animistic religion separate them from the largest group in the peninsula, the Malays, who are exclusively Moslems. They are mostly illiterate, but recent government policies have resulted in schools for them that use the Malay language as the medium of instruction. Very few aborigines can live independent of their jungle surroundings, but some are adjusting to a monetary economy, although they are economically marginal.

Physical characteristics, culture, and linguistic differences provide for a division of the aborigines into three major ethnic groups: the Negritos, the Senoi, and the aboriginal Malays (1). The Negritos are small, dark, curly-headed people who physically resemble aborigines in the Andaman Islands and the Philippines. They are the most primitive and isolated of all the groups and tend to be nomadic, relying primarily on hunting for their food. The Senoi group, whose origins are obscure, seem to be related to other hill tribes in Southeast Asia. They practice a shifting cultivation, raising rice, maize, and millet. They hunt with blow pipes and poison darts. The aboriginal Malays (proto-Malays) are those of Malay racial stock who never embraced Islam or other Malay customs. They tend to live in small groups in the lowland forest or mangrove swamps. Some of them have small rubber tree holdings, but most cannot live independent of the jungle. The breakdown by ethnic group and tribe is shown in table 1. As can be seen, about two-thirds live in the jungle fringe areas, where there is some contact with other cultures, and about one-third live in the isolated deep jungle areas.

The aborigines have a highly developed social organization. They live in extended family groups under chosen headmen. They have a great deal of individual freedom from early childhood and their behavior is only restricted insofar as it affects their relationship with other people. They belong to a nonviolent society and from an early age may not quarrel or show signs of aggression or greed. Cases of physical aggression among aborigines are extremely rare. One of the authors (J.M.B.) has not found any in nonpsychotic people in the past 16 years. This behavior has sometimes been idealized in the popular press (2). Since quarrels and fights are taboo, when there is a disagreement the aggrieved parties can either withdraw (and if necessary live elsewhere) or they can demand that the dispute be settled in accordance with their own legal custom. The dispute is judged by a headman equidistantly related to the two parties, who is assisted by other headmen in the area, with most of the villagers in

Dr. Kinzie is Assistant Professor of Psychiatry, University of Hawaii School of Medicine, Honolulu, Hawaii 96816. Dr. Bolton is Senior Medical Officer (for Aborigines) and Medical Director, Gombak Hospital, West Malaysia.

TABLE 1
Population of Ethnic Groups and Tribes

Ethnic Groups and Tribes	Deep Jungle Population	Fringe Population	Total Population	Number of Psychiatric Patients
Negritos	1,540	260	1,800	0
Senoi group			30,270	
Temiar	9,000	900		1*
Semai	7,000	8,500		8
Mahmeri		1,200		5
Others	200	3,470		0
Aborigine Malays			20,814	
Temuan		7,631		3
Jakun		8,995		3
Others		4,188		0
Totals	17,740	35,144	52,884	20

*From the deep jungle area.

attendance. Starting in the evening, the trial usually continues all night and, if not completed by morning, is continued the next evening. When all interested parties have stated their cases, the verdict is given. If the offense is serious, as when a man has run away with another man's wife, the fine is large and may take a number of years to be settled in kind.

Marriage is by mutual consent of the partners, but after marriage the wife is expected to share her time between her husband and her parents. It is taboo for a man to communicate with his mother-in-law or a woman with her father-in-law, even if they are living in the same house.

The aborigines believe in dreams as a source of communication. If a close relative living far away is sick they believe that they will be informed in a dream. They interpret dreams among themselves and are guided by what they learn from the dream. They also believe in spirits. The human race, both alive and departed, animals, trees, rivers, and the elements (e.g., thunder) all have spirits. Health depends upon being left unharmed by hostile spirits and crops depend on the help of spirits. Much time and energy is spent in appeasing various spirits. The spiritual advisors (*bomohs*) work themselves into a trance when, by their command over spirits, they help to cure disease or protect crops.

The usual aborigine reaction to stress, hostility, or difficulty is withdrawal. It they are outside the jungle they return to the jungle; if they are in the jungle away from their home, they return home; if they are at home, they run away from home. The aborigines are quite tolerant of some forms of deviant behavior and, as Denton pointed out in the case of the Semai (3), mentally ill aborigines usually receive custodial-like care in their village. They do not have the mechanisms in a legal or physical sense, however, to handle aggressive, disruptive behavior within the village or tribe. This form of uncontrollable behavior is usually handled by separation of the individual from the village. This is most easily effected in the deep jungle areas, where there is enough room for all parties concerned to depart from each other. However, this is not so easily done in the jungle fringe areas, where such disruptive behavior may involve members of other ethnic groups (Malays or Chinese) and thus create great social problems.

Medical Services

Throughout the past 15 years a form of medical service has evolved to care for the aborigines who populate remote and far-flung areas of West Malaysia (4). Now a rather elaborate medical complex has evolved with its center at Gombak Hospital, which is located 12 miles from the capital city of Kuala Lumpur. It is a 450-bed hospital whose staff are aborigine-trained aides and several Western-trained doctors. In addition, there are approximately 100 posts set up in the jungle that have trained staff who can give medical care for common diseases. These staff also have radio communication with the hospital and in emergencies helicopter service by the Royal Malaysian Air Force can provide rapid evacuation for patients throughout all the jungle areas to the central hospital. The hospital itself has attempted to provide modern medical care in a culturally approved manner. The aborigine staff has been useful in this, as has the practice of admitting families with the patient. The patient is encouraged to cook his own meals when possible and to use the surrounding jungle areas for hunting and fishing. The hospital has met with remarkable acceptance from the aborigine population.

PRESENTATION, DIAGNOSIS, AND TREATMENT

A problem in cross-cultural psychiatry is the diagnosis of patients from different cultural backgrounds. Often it has been difficult to know what is symptomatic behavior and what is culturally appropriate or acceptable in that setting. This problem is often more acute when no family members are available to give additional history or information regarding the patient's behavior. Our medical experience with the aborigines aided immensely in determining what was beyond the normal acceptable limits of behavior for these patients.

The diagnosis was made with the aid of the following procedures and information. First, most patients came from their village with some family members who described their behavior there. Second, the patient's behavior was observed at the Gombak aborigine hospital for a few days to a week before a formal psychiatric impression was obtained. Third, observations were made by aborigine field staff who were fully acquainted with the culture of the patient. Fourth, the mental status examination was administered by the psychiatrist who had previously worked in that culture. Perhaps one other factor that aided in diagnosis was that these cases generally involved severely disturbed individuals whose symptomatology was more obvious than that in patients who might have been less severely ill.

In the great majority of cases the patients were obviously impaired in functioning in their community. They

were not able to work or devote themselves to their families in the manner they had previously, or as did other members of the community. They tended to be socially disruptive, unpredictable, and uncontrollable, and they caused a great deal of concern to their own community. Although culturally sanctioned ideas, such as spirits and ghosts, were present in their thought processes, these were often used in a socially inappropriate way, which was recognized as abnormal by their peers and often by the patients themselves. Last, the patients often were quite aware of a subjective change in their abilities to perform and in their feelings, and in many cases they felt quite free to relate this openly. Thus, with the history and observations available from the mental status exams, a diagnosis could be given.

Diagnosis was made on the basis of APA's *Diagnostic and Statistical Manual of Mental Disorders*, second edition (5). However, schizophrenia was not broken down beyond acute or chronic, using "acute" to mean that the attack was the first one known to the medical staff and was of rather recent onset and "chronic" to mean that prior attacks had been recognized by the medical staff and that, in addition, the patient had had his symptoms over a period of time.

The distribution of the cases by tribes is shown in table 1. It can be seen that there were no patients from the Negrito tribe, and only one from a deep jungle area. In table 2, the 20 cases are listed with their diagnoses and predominant (presenting) symptom patterns. Twelve were men and eight were women. Half (ten) were between the ages of 20 and 30, five were between 30 and 40, and three were older than 40; two were below the age of 20. The age must be taken with a fair amount of caution, since aborigines generally do not accurately know their age. However, it can be seen that the majority of the patients were younger, as might be expected from this population. The great majority (16 of the 20 patients) were schizophrenic; nine were acute and seven were chronic. There were two cases of manic-depressive psychosis, one of anxiety neurosis, and one of psychosis associated with epilepsy. Paranoid symptomatology was present in six cases. No unusual or culture-bound symptom patterns existed, including those relating to the amok or latah syndromes, which are known to exist among Malays. No suicide occurred during this period; indeed, no suicide has ever been reported among the aborigines, although one patient had suicidal thoughts and another had a history of near-fatal suicidal behavior. There is a tendency for a great number of patients to wander away or to withdraw as a result of their symptoms. Indeed, this tends to be the predominant pattern. This is similar to other aborigine patients' reaction to stress—they withdraw, often returning to the jungle.

Social and psychological stresses, or preexisting personality disorders, are very difficult to determine since the history is often incomplete. In a few cases the stress would seem to have at least contributed to the illness. This was true of a woman who lost her eight children (patient 4); a young girl who was kept locked in a house for four years (patient 12); and a man whose wife and father died within one month of the onset of symptoms (patient 14). Several patients had preexisting life-styles suggestive of long-standing psychological or interpersonal problems. This included a man who considered himself "always fearful" and had a tic of grinding his teeth together (patient 10); another patient was described as "always very shy" and was too inhibited to ask the accepted and arranged girl to marry him (patient 13). In addition, there was a 27-year-old man who had never married, while a 38-year-old had married four times. These are unusual but not unacceptable behaviors. Two patients had recent histories of amebic dysentery and one woman was in the immediate postpartum period.

A real problem in the management of aborigine psychotic patients is their remoteness from the medical facilities and their difficulty in recognizing or accepting the need for long-term medical care. This is especially difficult since their concept of mental illness usually involves magic, and the belief that when the appropriate rituals are performed the illness should abate. A great help in West Malaysia has been the prior establishment of medical facilities for the aborigines. Thus, the psychiatric patients coming to Gombak are treated much the same way as the medical patients, and this seems to have resulted in their being less ostracized.

The following are some of the general principles of management that have proved effective. First, it seemed much better to keep the patients with other aborigines at the Gombak Hospital than to transfer them to the university hospital or a large governmental psychiatric facility where they would be in a minority group and unable to observe their usual customs. It has also been found extremely useful for the patients to come to Gombak with their families. There have been good results in keeping the family members together, much as many modern hospitals are doing. There was no attempt to isolate the psychiatric patients from other patients; that is, they are spread throughout the various wards of the hospital. In addition, the patients and their families are encouraged to carry on as many normal daily activities as possible, such as preparing their own meals and hunting and fishing in the surrounding areas. This method seems to have been helpful in the social rehabilitation of patients and approximates various modern therapeutic communities. Of the 20 patients seen, only three were hospitalized at other institutions, and two of these were hospitalized for very brief periods.

The phenothiazines were found to be especially important in the management of the schizophrenic patients; an important new contribution in this area has been the long-acting drug fluphenazine decanoate, which is injected intramuscularly. This drug could be given at intervals of three weeks to a month and provided excellent remission of the symptoms. The patients, after beginning treatment at Gombak Hospital, could be discharged to their jungle homes, where an aborigine staff member would administer the regular injection of fluphenazine decanoate on a monthly basis. Periodically the patients would be brought back to the hospital for psychiatric examination. Ten patients were treated in this manner

TABLE 2
Diagnoses and Symptom Patterns of the Patients

Patient	Tribe	Age	Sex	Diagnosis	Social Information	Symptom Pattern
1	Semai	21	M	Schizophrenia, chronic		Seven years of periodic disruptive behavior; multiple hospitalizations; refusal to take medicine; wanders and shouts at night.
2	Semai	50	M	Schizophrenia, chronic		Ten-year history of periodic disruptive behavior; multiple hospitalizations; runs away in jungle and bothers neighbors.
3	Semai	21	M	Schizophrenia, chronic; epilepsy (controlled)		Periodically becomes agitated, threatening, and belligerent; at times totally preoccupied and incomprehensible.
4	Semai	50	F	Schizophrenia, chronic	TB patient; has lost all eight children.	Third recurrence of symptoms after medicine stopped—agitation, insomnia, running away at night, fearfulness.
5	Semai	27	M	Manic-depressive, depressive type	Never married.	Two previous episodes of depression; now two to three months of feeling sad, difficulty sleeping, thoughts of suicide; hears own thoughts saying, "It is finished."
6	Semai	30	F	Schizophrenia, chronic		Five-year history; body immobile, hands fixed (catatonic); laughs to herself, crying at times; hears husband's voice; sees "river ghost"; is afraid.
7	Semai	35	M	Schizophrenia, chronic		Ten-year history; multiple hospitalizations; withdrawn; inappropriate smile; speech loose; paranoid.
8	Semai	21	M	Schizophrenia, chronic		Two years of insomnia, restlessness; auditory hallucination from his "soul"; speech incoherent at times.
9	Temiar*	17	M	Psychosis associated with epilepsy; possible mental retardation		Long history of epilepsy; refusal to take medicine; unmanageable in village; often runs away.
10	Mahmeri	23	M	Schizophrenia, acute	"Always fearful"; grinds teeth when anxious.	Very fearful of spirits "like men"; agitated, crying, runs away; sleeps away from family; has tic of grinding teeth.
11	Mahmeri	47	F	Schizophrenia, acute		Auditory hallucinations of women who want to kill her; afraid of dying; appears slow and uncommunicative; paranoid.
12	Mahmeri	18	F	Schizophrenia, acute	Locked up in uncle's house for four years.	Mute; periodically aggressive and crying; flat affect; unresponsive to environment.
13	Mahmeri	23	M	Schizophrenia, acute	Always been shy; "too shy to ask girl to marry him."	Laughs and smiles to himself; feels royal family is talking about him; unable to work; much of speech incomprehensible.
14	Mahmeri	38	M	Schizophrenia, acute	Wife and father died within past month.	Acts strangely, crying, always walking, restless; unpredictable behavior; speech is pressured and incoherent at times.
15	Temuan	41	F	Anxiety neurosis	Recent amebic dysentery.	Palpitations; dyspnea; difficulty walking and sleeping while in hospital for amebiasis.
16	Temuan	26	F	Schizophrenia, acute	In postpartum period.	Shouting and crying at times following delivery, saying people on wards out to hurt her and poison her (paranoid).
17	Temuan	23	F	Schizophrenia, acute		Uncooperative; withdrawn; feels people going to harm her; inappropriate smile; paranoid.
18	Jakun	40	M	Schizophrenia, acute	Recent history of amebic dysentery.	Uncommunicative; paranoid; singing at night; frightened and withdrawn.
19	Jakun	38	M	Manic-depressive, depressive type	Married four times.	Three prior suicide attempts (near-fatal); sad, anorexic; sleeps excessively; retarded speech.
20	Jakun	25	M	Schizophrenia, acute	He and brother loved same girl; felt depressed about this.	Worried; hears voices telling him to work; paranoid; speech only half comprehensible.

*From the deep jungle area.

throughout the year and the results so far have been excellent (6).

DISCUSSION

This report agrees with that of others (7) that one of the most remote and perhaps primitive groups of people existing in the 20th century do have psychiatric illnesses. The forms that these take, as seen by Western-trained doctors, by and large fit Western diagnostic classifications and respond to Western treatment. This report does not fulfill the need for field studies of an epidemiological type to determine the incidence of the various types of psychiatric disorders. Rather, it is a report on those patients who came to the attention of doctors as the re-

sult of their own behavior. All but one of these patients were psychotic. Usually they showed marked disruptive behavior or a personality change that impaired their ability to function in their own society. Often these patients became a social nuisance and an embarrassment to their group rather than a real physical threat. Only one person was diagnosed as having a neurotic disorder and no character disorders were seen. The fact that no exotic or culture-bound syndromes were seen is consistent with our impression that these are very rare among the aborigines, although it does not prove that they do not exist.

Some patients' symptoms had an obvious cultural overlay, for example, seeing a "river ghost" or "men-like spirits" or talking to one's "soul." These symptoms are consistent with some cultural beliefs but in all cases they were exaggerated or used inappropriately in the social context. They were also recognized as unusual by other aborigines. This is similar to the findings of Kiev with Indian immigrants in London (8).

It is significant that the primary symptom pattern has been one of withdrawal or running away. It appears that the basic personality trait of the aborigines, at least as observed by Westerners, is quiet shyness and in psychiatric illnesses this becomes more exaggerated so that the basic reaction is one of fear of others, a withdrawal and running away from the situation. Other forms of behavior such as aggression or amok are very unlikely to occur. This concept of an exaggeration of a life-style by psychopathology has been elaborated by Phillips and associates (9–11).

It is certainly interesting that all but one of the patients (an epileptic) were from the fringe areas, not the deep jungle, despite the fact that only one-third of the aborigines live there. Psychotic reactions do occur there and indeed we are personally aware of a few cases that did not come to light during the study period. However, the fringe area is where the greatest sociocultural disintegration has occurred among the aborigines when they are brought into contact with other ethnic groups. This sociocultural disintegration may itself be an etiological factor in the promotion of more mental illness, a concept that has been put forth by the Leightons and others (12, 13). In addition however, the more isolated tribes can have less need to put pressure on the psychotic individual. A socially disruptive person can perform without the social consequences that are so apparent when other groups or populations are nearby, i.e., he or the tribe can easily move to another place. In the fringe area, disruptive and antisocial behaviors have important consequences. A disturbed individual may involve neighboring Malay villagers, who usually barely tolerate an aborigine settlement at best. Therefore, members of the village may quickly respond to this individual and move him to a hospital to avoid further social embarrassment and untoward consequences.

In this study we noted that in one small group, the Mahmeri, consisting of only 1,200 people, there were five cases of acute schizophrenia during the year. In addition, several more cases in this area were known to the hospital staff. It is uncertain why this group had so many cases of schizophrenia. Whether there are any particular social or genetic factors relevant to this is unclear at this time, but it is an area that obviously deserves more study.

Modern psychiatric treatment can be integrated within a hospital setting of the type described above; when the cultural context of the patient is respected, psychiatric treatment can progress quite satisfactorily. In this setting, the psychiatrist acts primarily as a diagnostician and a consultant to the hospital staff in providing medical and social management for the patients. The staff itself, which is predominantly aborigine, with this encouragement can provide a socially therapeutic milieu for rehabilitation and treatment of these patients.

REFERENCES

1. Williams-Hunt PDR: An Introduction to Malayan Aborigines. Kuala Lumpur, Government Press, 1952
2. Stewart K: Dream theory in Malaya. Complex 6:21–33, 1951
3. Denton RM: Semai response to mental aberration. Bijdragen tot de Taal Land en Volkenkunde 124:135–158, 1968
4. Bolton JM: Medical services to aborigines in West Malaysia. Br Med J 2:818–823, 1968
5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968
6. Kinzie JD, Simons RC: Outpatient treatment of psychotic patients with a long-acting phenothiazine: fluphenazine decanoate. Med J Malaya 26:129–132, 1971
7. Benedict PK, Jacks I: Mental illness in primitive societies. Psychiatry 17:377–389, 1954
8. Kiev A: Beliefs and delusions of West Indian immigrants to London. Br J Psychiatry 109:356–363, 1963
9. Phillips L, Rabenovitch MS: Social role and patterns of symptomatic behaviors. J Abnorm Soc Psychol 57:181–186, 1958
10. Phillips L, Broverman IK, Zegler E: Sphere dominance, role orientation, and diagnosis. J Abnorm Soc Psychol 73:306–312, 1968
11. Phillips L, Draguns J: Some issues in intercultural research on psychopathology, in Mental Health Research in Asia and the Pacific. Edited by Caudill W, Lin TY. Honolulu, East-West Center Press, 1969, pp 21–32
12. Leighton DC, Harding JS, Macklin DB, et al: The Character of Danger: Psychiatric Symptoms in Selected Communities. New York, Basic Books, 1963
13. Leighton AH: A comparative study of psychiatric disorder in Nigeria and rural North America, in Changing Perspectives in Mental Illness. Edited by Plog SC, Edgerton RB. New York, Holt, Rinehart & Winston, 1969, pp 179–199

Duodenal Ulcer Among Northwest Coastal Indian Women

BY JAMES H. SHORE, M.D., AND DENNIS L. STONE, M.D.

Indian women from a Northwest coastal tribe were noted to have a high prevalence rate of duodenal ulcer, about four times greater than that for non-Indian women and above the rate of occurrence in Southwestern Indians. The authors analyze this high rate in light of the cultural heritage and current acculturation stresses, discussing the historical role of Northwest Indian women in a matrilineal culture and pressures on the Indian woman who lives in a minority-group/poverty-level community.

A PSYCHIATRIC EPIDEMIOLOGIC SURVEY (1) of a Northwest coastal American Indian tribe in 1969 reported a prevalence of peptic ulcers of seven percent, or two-and-one-half times the national average. It was hypothesized that both individual stress and rapid cultural change in this Indian population played a determining role. Hypertension was not a common occurrence among the population, although an increased frequency of hypertension had previously been reported in other groups under acculturation stress (2). The findings raised the question of genetic and sociocultural determination of the organs involved in psychosomatic illness.

In the summer of 1970, a follow-up study was carried out to determine the accuracy of the original observations. In this report gastric ulcers were excluded, since these are normo- or hyposecretory and represent a different disease than hypersecretory duodenal ulcers. The confirmation project had three goals: 1) to define the prevalence of duodenal ulcers for the entire population of this Indian tribe; 2) to compare the prevalence of these ulcers with that described in the earlier study, which reported on a sample of 100 adults; and 3) to test the validity of a field questionnaire for diagnosing peptic ulcers in this Indian population.

THE INDIAN VILLAGE

Pacific Northwest coastal Indians had little contact with Westerners until about 100 years ago. Since that time there have been many changes in governmental systems, education, and social relationships. Several tribes continue to reside near their original location, which was set aside as a reservation. Although these tribes, as a people and a culture, are in a state of transition, they are sufficiently demarcated geographically and ethnically to provide an easily identifiable group for epidemiological study. While there is a wealth of anthropological information among the Indians and a common presumption exists that they are a psychiatrically high-risk group, few previous systematic epidemiological studies have been done.

The Indian tribe we studied is located in a small, isolated fishing and lumbering village on the Pacific Northwest coast. Historically, these people, who were primarily seafaring, spent much of their time near water. Fishing and whale hunting, with elaborate rituals, had essential roles in their lives. An aggressive, warlike people, they made frequent raids on their neighbors and returned with captured slaves. The potlatch, the ceremonial feast of giving, provided an alternative to warfare—a means to humble rivals and to enhance the prestige of community leaders. After the treaty with the U.S. government in the 19th century and with the arrival of the Indian agent, the tribe members' lives were influenced by a prohibition of their tribal customs, by suppression of their potlatch ceremonies, and by forced education in English-speaking boarding schools. Following the Indian Reorganization Act in 1934, they obtained the right to self-rule and currently have an effective tribal council. The reservation presents opportunities for lumbering, fishing, and tourist industries, which the tribe has utilized. However, the average family income of approximately $3,200 a year remains below the poverty level.

With the assistance of the Indian Health Service, certain widespread infectious diseases such as tuberculosis have been largely eliminated. However, in many ways this group shares common problems with other American minority groups living within or below the poverty level. For example, the infant mortality rate for western Washington Indians continues to be high when compared with that of the United States as a whole (41 versus 21 per 1,000) (3).

PSYCHIATRIC EPIDEMIOLOGIC SURVEY: INITIAL FINDINGS

The psychiatric epidemiologic survey (1) was done in 1969 with a sample selected from a total village popu-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1-5, 1972.

Dr. Shore is Chief, Mental Health Office, Portland Area Indian Health Service, Rm. 200 Pittock Block, 921 S.W. Washington St., Portland, Ore. 97205. At the time this work was done, Dr. Stone was a senior medical student, University of Oregon Medical School, Portland, Ore. Currently he is Geriatrician, On Loc Senior Citizens Health Program, San Francisco, Calif.

The authors wish to thank Ms. Carolyn Dearborn, Program Assistant, Portland Area Mental Health Office, for her valuable assistance.

lation of 500. In the initial survey all Indians younger than 20 years of age were excluded, leaving a total adult Indian population of approximately 200 persons. The 100 subjects selected from the adult population were controlled for certain variables as follows: 1) there were an equal number of men and women; 2) there was a random distribution for geographic places of residence within the village; and 3) there was a representative distribution for each decade of life proportionate to the distribution by decade of the entire adult population.

A determination of probable psychiatric disturbance was made in 69 percent of all of the subjects evaluated. Forty-seven percent of all subjects were judged to have significant psychiatric impairment. These rates were manifestly higher than those in other comparable studies. However, the major differences in the prevalence of psychiatric and psychophysiologic disorders appeared to lie in higher rates of alcoholism and peptic ulcers. (A diagnosis of peptic ulcer was made when the subject was currently being treated for that condition by the local physician. A majority of patients had a positive radiologic diagnosis.) In other aspects the findings were similar to those reported by the Leightons (4–6) in Nova Scotia and Nigeria and by Gillis and associates (7) in South Africa.

Psychiatric impairment from alcoholism and from peptic ulcer were not directly related. The prevalence for alcoholism was reported at 27 percent; it was twice as common among Indian men and the most common diagnosis for them. Indian women more often had psychoneurotic (18 percent) and psychophysiologic disorders (9 percent). The high occurrence of peptic ulcer represented a male-female ratio of one to three, a reversal of the U.S. ratio. In addition, a higher rate of psychiatric morbidity was found in those subjects exposed to the most social disorganization: those in the age group who grew up in the village after a road had been built; those who moved into the village from the outside; and those from the lowest Indian social class.

Although the psychiatric epidemiologic findings supported the hypothesis that social disorganization was related to increased psychiatric morbidity in this Indian community, this relationship was not true for peptic ulcers when analyzed separately. Where the prevalence of ulcers was high, significant psychiatric impairment concomitant with this diagnosis was low. Six of the 15 ulcer subjects were judged to have no psychiatric impairment.

THE FOLLOW-UP STUDY

During 1970, one of us (D.L.S.) lived in the Indian community while conducting the duodenal ulcer study. A medical chart survey was done on all records. The chart review guide included information on demographic, social, and employment history along with a complete review of the patient's medical history, emphasizing the ulcer history. A presumptive diagnosis of duodenal ulcer was made on the basis of the following criteria: 1) medical history—epigastric pain, a relationship to eating, gastrointestinal bleeding; 2) medication history—antacids and anticholinergics; and 3) radiologic diagnosis.

Six hundred thirty-four medical records were reviewed. This number closely approximates the total population of the tribe. Fifty-two percent of these records were those of Indian men, and 48 percent were those of women. Of the Indian population, 53 percent were younger than 20 years of age. There were 56 Indian patients with a presumptive diagnosis of duodenal ulcer. There was no direct evidence of duodenal ulcer from autopsy since no postmortem examinations had been completed on deceased ulcer patients. The patients were all living, and their ulcers were documented by clinical history and medical treatment. Twenty-three of the patients were men and 33 were women. During the 12-month survey, 12 men and 18 women had active lesions and were under treatment for duodenal ulcer disease. The active case prevalence rate for duodenal ulcers was 19 per 1,000 for men and 28 per 1,000 for women; the male-female ratio was 1 to 1.5.

Duodenal ulcer disease occurred most frequently among Indian men between the ages of 20 and 40 and among Indian women between the ages of 20 and 50. The Indian woman experiences the onset of peptic ulcer disease at an earlier age than the Indian man; seven of the nine ulcer cases that occurred during adolescence were in women. There were no significant differences between the ulcer patients and the general population with regard to family status, marital status, number of children, type of employment, or employment history. The Indian women with peptic ulcer disease visited the health clinic two to three times as frequently as the Indian men with the same disease. According to an informant-rated drinking scale, the active and inactive ulcer groups were equally represented throughout the range of drinking behaviors. Duodenal ulcer occurred more frequently among patients with a mixed Indian heritage than among those of pure Indian descent. This trend appears to be significant when compared with a total population sample and is of greater significance for Indian women. Of 34 ulcer patients with a mixed descent, 28 were one-half or less Indian (see table 1). Intermarried non-Indians were not included in the study.

Forty-three patients (12 men and 31 women) had upper gastrointestinal X-ray studies; 19 of these had multiple studies. A definite diagnosis of duodenal ulcer was made for five men and for 22 women. Four men and six women were reported to have a suspected diagnosis by X ray, while three men and three women had a negative series. Two men and 18 women with a definite diagnosis by X ray were in the active duodenal ulcer category.

THE QUESTIONNAIRES

In order to better understand the Indian patient's response to peptic ulcer disease two questionnaires were utilized. The first questionnaire consisted of 11 items dealing with gastrointestinal problems from the Cornell

TABLE 1
Relation of Indian Descent to Duodenal Ulcer Disease

Descent	Ulcer Patients (N = 56)		Tribal Population Sample (N = 100)
	Men	Women	
Full Indian descent	12	10*	74
Mixed descent	11	23*	26

*Difference between men and women significant at $p<.01$ level.

Medical Index (cited in Epstein [8]). The second questionnaire was a battery of six questions used by Dunn (cited in Epstein [8]) that attempted to define the pattern of stomach pain, its relationship to meals, and response to eating. We interviewed 35 patients who came to the village clinic for any reason. Twenty of these patients had no evidence of peptic ulcer disease, while 15 had both a clinical history and a confirmed diagnosis of peptic ulcer.

The data from both questionnaires were analyzed in three categories: 1) sensitivity—the proportion of true positive cases that were diagnosed as positive by the questions; 2) specificity— the proportion of true negative cases that were diagnosed as negative by the questions; and 3) relative risk—a formula assessing the diagnostic accuracy of the questions. The Cornell Medical Index (11 items) yielded a score that clearly distinguished between the ulcer and nonulcer groups. With a criterion of five positive answers, the sensitivity of Indian patients was .73. This score is similar to a sensitivity score reported by Epstein (8) in an ethnically heterogeneous population. Using the Dunn questionnaire, the first question, "Have you ever been troubled with episodes of stomach pain or stomachache?" accurately identified the peptic ulcer patients. However, if the patients with peptic ulcer disease were required to differentiate the pattern of their stomach pain, the accuracy of the Dunn questions dropped off markedly.

From the results of the two questionnaires we concluded that the Indian group with peptic ulcers can be clearly distinguished from a nonulcer Indian control group with regard to their experience of ulcer symptomatology; this difference between the groups is similar to that in a non-Indian population. Unlike persons from the Middle East or Asia, who tended to answer "yes" whether they had had an ulcer or not (8), our control group can be clearly distinguished from the peptic ulcer patients by their negative response. A number of factors may explain the high correlation of positive answers to symptomatology in the ulcer group. These factors include: education by the physician about the nature of expected peptic ulcer symptoms; reinforcement of symptoms among a specific patient group in the village; and an ability to accurately interpret the question of gastrointestinal symptomatology. It is unclear whether these questionnaires would accurately predict the occurrence of peptic ulcer disease in this population if the patients were selected on a random prospective basis.

DISCUSSION

A prevalence rate of 19 cases per 1,000 and of 28 cases per 1,000 for men and women, respectively, confirms the high rate of duodenal ulcer disease in this Northwest coastal Indian population. In the U.S. National Health Survey (9), respondents from a national sample reported illnesses experienced within the preceding 12 months. For men the prevalence rate of peptic ulcers was 21.6 cases per 1,000 and for women 7.7 per 1,000. This rate agreed with that obtained in other U.S. health surveys conducted in the 1950s (10, 11). A comparison of the prevalence rate for the entire United States with this Northwest Indian tribe confirms that the tribe has a high rate of duodenal ulcer. It also shows that while the prevalence rate in Indian men is almost identical to that of the entire U.S. population, the rate for Indian women is about four times the rate for all U.S. women in the national survey. Although this supports the initial findings of the psychiatric epidemiologic study, the follow-up project produced some differences. The male-female ratio of duodenal ulcer disease in the total Indian population is 1 to 1.5 instead of the 1 to 3 reported in the initial pilot project. The prevalence rate for the entire Indian population is close to five percent. The difference between five percent and seven percent described in the pilot project probably reflects stricter criteria for diagnosis of duodenal ulcer disease in the follow-up project. The difference in sex ratios may represent a sampling error of an underrepresentation of Indian men with ulcer disease in the initial sample; however, the high prevalence rate of duodenal ulcer disease in Indian women remains significant. The prevalence rate of five percent in the Indians is significantly greater than the U.S. rate of three percent.

In contrast to these findings, Sievers and Marquis (12) reported a striking absence of duodenal ulcer among Southwestern tribes. In an eight-year hospital study only three Indian patients with duodenal ulcers were discovered, and all were from non-Southwestern tribes. Sievers (13) discovered a significantly greater frequency of achlorhydria among Southwestern Indians than among Caucasiáns; this finding is compatible with the observed deficit of duodenal ulcer in those Indian tribes. On the other hand, the prevalence of gall bladder disease is significantly greater among Southwestern American Indians than among Caucasians (14). In the tribe we studied, while patients with a full Indian heritage were diagnosed with duodenal ulcer disease, there was the significant trend for those with a mixed heritage, especially the women, to experience more ulcer disease.

The high incidence of duodenal ulcer disease among the Indian women requires additional explanation. Historically, this Northwest Indian tribe was divided into social units based on matrilineal descent. Membership in social divisions, inheritance of social position, and worldly goods came to each individual from the mother's side of the family. In modern society these historic practices may be reinforced in rural Indian communities with high rates of unemployment and low incomes. The Indian man is sometimes unable to contribute income or

prestige to the household. As a result, the maternal influence in the family is reinforced. Such situations exist among people of east London, among minority families inhabiting the ghettos of North America, and among rural Indians living in poverty conditions. The historical role of the Northwest Indian women in a matrilineal culture may unite with the modern-day pressures of the woman's role in a minority-poverty community to increase the prevalence rate of duodenal ulcer disease.

Changes in the incidence of peptic ulcer among women in other cultures have emphasized the role of environment. Dramatic changes in northwest Europe have been noted in the past 150 years (15). Perforations occurred with increasing frequency early in the 19th century, young women being the chief sufferers. This trend reached a peak during the latter half of the century and then began to disappear. In Northwest coastal tribes her role in family responsibility, ambition, and strivings may place the woman in a position of psychological stress unique to her cultural heritage and local community and may predispose her to a higher susceptibility to peptic ulcer pathology.

Both psychoneurotic and psychophysiologic patterns described in the initial psychiatric epidemiologic study were also largely found in women. The majority of subjects with impairment from alcohol abuse were men. The women with impairment from a psychoneurotic condition were all known to the physician as patients and required a good deal of medication. The women with ulcers visited the clinic twice as frequently as men with the same illness.

In a comprehensive review of the literature on peptic ulcers Susser (16) concluded that "variations of peptic ulcer in different geographical, historical, and social contexts are unequivocal evidence of the influence of ways of life in this illness. The specific elements that contribute to the variations probably include diet, alcohol, cigarette smoking, emotional strain, personality and genotype." It is interesting that in other Northwest tribes the rates of diabetes mellitus and rheumatoid arthritis are significantly higher (17) for particular tribal groups, while the increased prevalence of duodenal ulcer is uniquely characteristic of the tribe we studied. It seems likely that in this tribe both individual emotional stress (particularly as experienced by the woman) and a pattern of rapid cultural change have influenced the rate of duodenal ulcer disease.

REFERENCES

1. Shore JH, Kinzie JD, Hampson JL, et al: Psychiatric epidemiology of an Indian village. Psychiatry 36:70–81, 1973
2. Schulze VE, Schwab EH: Arteriolar hypertension in the Negro. Am Heart J 11:66–70, 1936
3. US Public Health Service: Portland Area Indian Health Service, Vital Statistics 1965–1970. Portland, Ore, Portland Area Indian Health Service, 1971
4. Leighton AH: My Name Is Legion: Foundation for a Theory of Man in Relation to Culture. New York, Basic Books, 1959
5. Leighton AH, Leighton DC, Hardin JS, et al: The Character of Danger. New York, Basic Books, 1963
6. Leighton AH, Lambo TA, Hughes CC, et al: Psychiatric Disorder Among the Yoruba. New York, Cornell University Press, 1963
7. Gillis LS, Lewis JB, Slabbert M: Psychiatric disorder amongst the coloured people of the Cape Peninsula: an epidemiological study. Br J Psychiatry 114:1575–1588, 1968
8. Epstein LM: Validity of a questionnaire for diagnosis of peptic ulcer in an ethnically heterogeneous population. J Chronic Dis 22:49–55, 1969
9. US National Health Survey, US Public Health Service: Reporting of Hospitalization in the Health Interview Survey. Publication 584-DU. Washington, DC, US Government Printing Office, 1961
10. Peterson WA: Kansas City Metropolitan Health Survey. Kansas City, Mo, Community Studies, 1959
11. Department of Public Health, State of California: Health in California. Sacramento, California State Printing Office, 1957
12. Sievers ML, Marquis JR: Duodenal ulcer among Southwestern American Indians. Gastroenterology 42:566–569, 1962
13. Sievers ML: A study of Achlorhydria among Southwestern American Indians. Gastroenterology 45:99–108, 1966
14. Sievers ML, Marquis JR: The Southwestern American Indian's burden: biliary disease. JAMA 182:172–174, 1962
15. Jennings D: Perforated peptic ulcer: changes in age incidence and sex distribution in last 150 years. Lancet 1:395–398, 444–447, 1940
16. Susser M: Causes of peptic ulcer. J Chronic Dis 20:435–456, 1967
17. US Public Health Service: Portland Area Indian Health Service, Ambulatory Patient Care Report 1C, Visits by Diagnosis. Portland, Ore, Portland Area Indian Health Service, 1971

Answers to Questions of the Month

Page 764. Question 1:C; Question 2:B.

Children's Reactions to Temporary Loss of the Father

BY FRANK E. CRUMLEY, M.D., AND RONALD S. BLUMENTHAL, A.C.S.W.

The impact of separation from a parent is recognized as a crucial factor in a child's development. Forced military separations also lead to clinically observable reactions in children. This long-term loss of the father is considered a developmental interference resulting in a disturbance in the typical unfolding of the child's personality. Important treatment considerations flow from understanding the impact this has on the child.

SEVERAL REPORTS OF CHILDREN of servicemen have included a discussion of the effects of the father's absence during a hardship tour (1–7). Pederson (4) emphasized the importance of the mother's ability to mediate the effects of the father's absence. Her relationship to the child was crucial in determining the effect of the separation. Pederson found that by age 15, 85 percent of the children referred to an Army psychiatry clinic will have experienced long-term separation from their fathers. The data pointed toward a cumulative influence on the disturbed child no matter how subtle it might be within a single period of absence.

Gabower's report matched a military control group with children referred for psychiatric help and suggested that separation from the father was related to the child's behavior problems (2). Gonzalez (7) observed that "the type of reaction depends on numerous variables including age of children, length of absence, previous emotional adjustment of family, the prior quality of father-child relationship, and the role of the father in the family." In view of the pervasive experience of prolonged separation from the father within the military family, it is surprising how relatively little attention has been focused on this facet of such children's lives.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Crumley is Clinical Instructor in Psychiatry, University of Texas, Southwestern Medical School, Dallas, Tex. He is also in private practice at 3613 Cedar Springs Rd., Dallas, Tex. 75219. Mr. Blumenthal is District Seven Director, B'Nai B'Rith Youth Organization, Dallas, Tex.

Several reviews of the literature have commented on the importance of differentiating the effects of particular types of paternal separation, such as occupational absences, divorce, and death (8). The socioeconomic status of the children studied must also be considered, and sometimes this appears to overshadow the role of separation (9). The military community offers an unusual opportunity to observe the effects of a temporary separation from the father that is uncomplicated by marginal economic circumstances or by the marital conflict surrounding divorce. Relatively little attention has been given to the dynamic implications of temporary loss of the father secondary to an occupational separation. An awareness of the importance that this loss can have for a child is valuable in treatment.

SOURCE OF THE DATA

The clinical data are based on psychiatric evaluations of approximately 200 children and parents whom we evaluated in an Army child psychiatric clinic during the years 1969 and 1970. Special attention was paid to a history of separation from the father during duty tours. An analysis of the clinic population based on 100 consecutive patients revealed a very homogeneous socioeconomic group of families. Ninety-one percent were in the middle class (career sergeants). The age range was from 3 to 18 years (61 percent between three and five years and 26 percent between 14 and 18 years). Ninety-six percent were Caucasian. Boys predominated, 63 percent to 37 percent.

Referral sources were predominantly schools and physicians, with only five patients sent by juvenile courts or police. Separation from the father was a regularly occurring event in the life history of almost all of these patients. Thirty percent did not have a father living in the home at the time of referral. Diagnostic categories were generally comparable to other clinic reports after controlling for differences in socioeconomic class (10–12). Comparisons with other reports from military clinics were hampered by differences in collecting the data, in selecting the sample population, or in diagnostic classification (3, 13, 14).

FINDINGS

We consider the cycle of separation and reunion a developmental interference in the sense described by Nagera (15). It constitutes a gross external interference with certain needs and rights of the child. The disturbance surrounding the temporary loss of the father cannot be separated from the crises of reunion. The whole cycle of departure, interim, and reunion represents a continuum the child faces at critical times in his development regardless of his ego capacity to deal with the situation. Consequently, for these disturbed children, the effect was one of leaving psychological scars on their developing psychic structures.

Early reactions to the father's departure resembled those of other children at a similar developmental level following loss of a parent, specifically the father, by death (16). These reactions included the following: 1) rageful protests over desertion, 2) denial of loss and maintenance of an intense fantasy relationship with the lost parent, 3) persistent efforts at reunion and restitution, 4) arousal of irrational guilt and need for punishment, 5) exaggerated separation anxieties and fears of abandonment, 6) splitting of ambivalence toward the lost parent with a redirection of the hostility toward the self or another, 7) a strong sense of narcissistic injury, 8) decrease of ego control following loss of ego and superego support, and 9) precipitation of a wide variety of regressive symptoms (17–19).

Frequently the reactions could be observed in anticipation of loss. Understandably, there was less need for massive denial and complete reversal of affect typical of latency-aged children who have lost a parent by death.

In these disturbed families the reactions to the father's leaving more closely resembled those following separation by divorce. Father was gone but not really gone (20–26). Not infrequently, separation was more or less consciously desired by the parents as a means of easing marital conflicts and of avoiding dangerous intimacy. Some couples seemed to mutually encourage periodic separations as if by an unspoken agreement. Frequently a mother would declare that the only thing holding her marriage together was the relief of intermittent separations. One mother was confident her son's obnoxious behavior would end as soon as his irritating, intolerable father left on another tour. These rationalizations of inevitabilities were seen as partially accurate descriptions of family relationships. Under such circumstances the father's departure for duty was even more easily seen by the child as an expression of hostility on the part of the parent. The child's tendency to guiltily blame himself and to view the separation as punishment was encouraged by the climate of emotional divorce prior to separation.

During the interim period, numerous changes in family dynamics were required to compensate for the father's absence. The entire remnant family appeared to turn inward as if nurturing a wound. Frequently the remaining family returned to the grandparents' home while the father joined his military "parent unit."

There was a mutual attempt by the mother and the child to replace the lost family member. One child usually moved into the mother's bed. One—usually the oldest boy—took over the father's chores at home. Personality traits of the father became magnified by the child in an exaggerated defensive identification. An intense search for replacements extended outside the family to neighbors and to schoolteachers, as well as to other family members. Simultaneously, contact with the distant father was usually maintained by letters, gifts, and verbal recordings. Often an increased emotional attachment to an idealized memory of the father developed.

The father's return aroused a reemergence of the feelings associated with his departure. The adjustments painfully made during his absence had to be undone and new alignments formed. The father's reentry triggered an exacerbation of symptoms that may have quieted during the interim period. Frequently, delayed reactions became manifest now that father was safely home and the threat of permanent loss abated. Dramatic reactions were more common among teen-agers: A 15-year-old girl became incapacitated by sudden compulsive symptoms; an effeminate 15-year-old boy could not attend school because of hysterical ataxia; a compulsive 14-year-old anorexic girl lost 30 pounds on an extreme diet following her father's return.

It is this cycle of departure and interim absence followed by return that distinguishes this type of parental loss from loss by death, divorce, or abandonment. This pattern is repeated over and over again for many of these children. Several areas of the child's development seem to be particularly affected by this cycle of events: 1) superego formation, 2) the capacity to tolerate object loss, and 3) object relations.

SUPEREGO

Marked vacillations occurred in what these disturbed families allowed or did not allow depending on whether or not the father was home. This seemed to make it more difficult for the children to internalize a consistent set of standards independent of the presence or absence of external authority. Many children seemed to rely more on strong visual, external ego and superego supports, such as those provided by the military culture. Once removed from this, they were very vulnerable. One conscientious adolescent became terrified of his own moral laxity while he was away from home and the military base during the summer.

If the father was seen by the child as a primary source of external ego and superego support, separation was often followed by disobedience, a decline in school performance, and aggressive antisocial behavior. Sometimes the child seemed driven to bring punishment on himself as if he were guilty of having caused the father to leave. Often, aggressive behavior was employed to fight against a regressive pull toward the mother during the father's absence. Acting out protected the latency-aged boy's ego from fear of a feminine identification and the girl from a passive overinvolvement with the mother.

Sometimes the mother unconsciously encouraged aggressive acting out as an expression of her own anger toward her absent husband. The disturbance often seemed designed to bring the father home: "If I am bad enough, Father will come home to stop me and take care of me." Explicit pleas along these lines were frequently voiced. The father's absence provided fertile soil for nurturing sanctions for superego lacunae.

Less frequently the child's intense anger at his father for leaving and his guilty fear of the father's punishment contributed to the formation of a harsh, overstrict superego. The child became overly conscientious and compulsively dutiful. Latency defenses were rigidly overdeveloped and entry into adolescence was delayed or aborted.

When the father returned, new readjustments were again painfully required. His actual presence became an intruding overload in the face of interim defensive adjustments. The contrast between the idealized parent and the reality became more difficult to avoid. Noticeable changes in the child's ability to control his behavior were apparent. Readjustments were required as the internalization of controls again became based on a daily living interaction with both parents rather than with one. It is the repeated shift of defenses and identifications that reinforced certain deficiencies in the children's superego consolidation.

Case 1. "All right, you yardbirds, where is the doctor?" bellowed the seven-and-a-half-year-old son of a drill sergeant as he swaggered into the reception room with his hands on his hips. He had been referred because of his aggressive behavior, encopresis, stealing, disobedience, hyperactivity, temper tantrums, nervousness, and underachievement in school. His encopresis started at age six during his first year in school when his father had left for a year-long tour of duty. Six months later his father was hospitalized briefly following a cranial wound. (His father had also been absent the first six months of his life.)

According to his mother, Randy's father had a bad temper and left marks on his son after disciplining him. The father had grown up without a father himself because his parents were separated.

Randy was a sturdy, muscular boy who spoke in a loud voice and acted at times like a miniature drill sergeant and at other times like a frightened little boy, periodically reverting to baby talk. He described his father as yelling too much and favoring his younger twin brother. He was an extremely angry boy, with strong feelings of inferiority and a compensatory need to please. He tried desperately to elicit approval and praise. "They think I'm real mean. I feel like leaving home, that's what I feel." He didn't like those "dumb recruits" that kept his father away from home.

He showed improvement when the father began taking more interest in him and taking him to Indian Guide meetings but regressed to sulking and aggressive behavior three months later after hearing his father would be leaving for another assignment. His mother said, "He goes around like he's going to cry about everything."

DEPRESSION

Depressive responses were a frequent finding among these disturbed children. Evidence of latent depression was seen in a wide variety of symptoms, including psychosomatic complaints, learning problems, running away, and sexual or aggressive acting out (27, 28). In most cases the onset or exacerbation of symptoms could be dated to the departure or return of the father.

More interesting, however, was the number of children who showed various degrees of overt affective depression similar to the cases described by Poznanski and Zrull (29). These children appeared sad, withdrawn, unhappy, tearful, and spoke disparagingly about themselves. They had difficulty handling aggressive feelings and frequently were rejected by or scapegoated within the family. Usually the mother's depression was strikingly apparent in the family picture. The depression was not simply a reaction to loss of the father but, rather, a complex phenomenon related to the child's typical defensive pattern. Persistent themes of helplessness, powerlessness, and impotence in the face of overwhelming uncontrollable forces permeated many families. Children worried in trepidation of seemingly inevitable separation or reacted to an ongoing loss as if the father were always gone. Parental omnipotence was shattered by the parents' inability to prevent disunion of the family. A strong sense of narcissistic injury marked the child's self-image. Many children experienced the separation as an unjust loss of love and demanded compensating expressions of love from the mother. Some were impelled to vindictively prove how mistreated they were as if to force the father to return.

Case 2. Seven-and-a-half-year-old Cindy cried sadly as she told of worrying about her absent father never coming back. She cuddled a doll in her arms and, with a daydreaming look, romanticized. "I want to go where Daddy is and stay with him." Since her father's departure for overseas duty six months previously, she had been worrying incessantly. She had developed symptoms of school phobia and clung to her mother for fear that she, too, might not return. Each school day she cried and complained of headaches. She had difficulty keeping friends because she tended to boss them and lost her temper easily. The mother later called for an appointment for herself, complaining of depression: "I can see how I've been affecting the children."

Case 3. Nine-and-a-half-year-old Paul was referred six months after his father returned from being away because he was excessively "nervous" and "shaky." He often shut himself in his room and cried. He was a sad, red-haired, freckle-faced boy who tended to assume a pseudomature, superior attitude as he spoke in a sedate monotone. He seemed to be a distant, reserved, hard-to-get-to-know youngster. He acknowledged feeling sad and bad at times but didn't know why. He complained of being "bothered by his conscience a lot." He felt unable to please his father and was sure his father thought he was a "sissy." His mother cried when describing the lack of affection between father and son. Alternating a year at home and a year away, the father had been gone a year when Paul was three, five, and seven.

OBJECT RELATIONS

Separation from the father appeared to accentuate

long-standing deficiencies in father-son relationships. In some cases evidence of difficulties in father-son relationships could be traced back through three generations. Sometimes the father's father had also been a career military man and had been out of the home most of the time. Not infrequently, the disturbed child's father had joined the Army to compensate for his own deprived emotional contacts at home. One father felt he had no real family when he joined the Army at age 15. Another was never sure he could distinguish his own father from his uncle. One father (a drill instructor) of an aggressive patient had been reared by his mother alone after she and her husband had separated.

The fathers seemed to have re-created with their sons the poor relationship they themselves had experienced as children. Their own deficient masculine self-image was bolstered by assuming a super-soldier role and by an attempt to mold their sons in this image. Often the son felt completely unable to live up to this ideal expectation and felt rejected by the father. The child's anger at his parent was then turned inward against himself or outward toward others as acting out. Sexual identifications were inadequately developed.

These long-standing personality problems were aggravated by intermittent separations that offered less chance for a stable, enduring father-son relationship in a give-and-take situation. During periods of absence, fantasy idealizations were developed with expectations of changes when the father returned. Each disappointing reunion was taken as fresh evidence of rejection and loss.

Relations with the remaining parent became regularly more difficult as the father was intermittently absent. The rage experienced over the loss of the father was often split off and redirected toward others. This encouraged the development of an extremely ambivalent relationship with the remaining parent. Just as with the child who has permanently lost a parent, relations with the other parent became distorted and highly ambivalent (23, 30, 31).

These children consistently had difficulty making and keeping friends. They seemed to expect a high degree of impermanence in their relationships with others and avoided closeness. Expectations of frequent loss were transferred to friends. The father's impermanence and corresponding changes in the relationship with the mother set the theme for subsequent object relations.

Deficiencies in masculine identity were apparent among the boys who had distorted relationships with their fathers. This also contributed to their difficulties in finding acceptance among peers. Rejection by peers further deflated their inadequate self-image and encouraged defensive efforts to prove they were not effeminate. By adolescence a continued rejection of anything they perceived as related to femininity interfered with the development of heterosexual relationships.

Case 4. Eleven-and-a-half-year-old John had been encopretic since his father had gone on a 12-month tour a year and a half previously. John was a friendly, talkative boy. He anxiously explained. "I don't like going around smelling like a skunk, but I'm so nervous I do it in my pants to get it all out of me." He had a few friends but preferred to withdraw into books. His father complained: "He cries everytime you look at him." John considered himself an "84-pound weakling" and sadly joked about his "accident-prone bike" that was "just like a girl's." He liked to play with model Army soldiers, but if he had a wish, he'd "make everybody happy" and "stop the war in Viet Nam." He didn't like people dying and became tearful when recalling the death of his grandmother three years previously. He had tried to talk this over with his mother, but she had just told him not to worry. "Sometimes," he remarked in a serious tone, "I get so mad I cry. Father says I shouldn't cry."

DISCUSSION

We must emphasize the preliminary nature of our report. A more definitive study would require a more rigid methodology and would include control groups. Our interpretations are therefore advanced with caution since other possibly relevant factors could not be excluded. In no way is it implied that separation from the father was the sole factor involved in the development of pathology in these children. Rather, it is hoped that this clinical report will stimulate greater recognition of the effects of temporary paternal loss.

With this in mind we wish to point out several therapeutically relevant trends observed in the current study. Absence of the father appeared to be an important factor in the pathological development of these children. This was seen not only in the repeated relationship between the development of symptoms and the departure or return of the father, but also in certain prominent personality characteristics of the children that could be related to temporary father absence.

An awareness of the dynamics of the child's reaction to loss of the father and its complex effect on the family was important in working with the child in therapy. Helping the child become aware of his feelings of abandonment, rage, helplessness, and worthlessness associated with his father's absence seemed to accelerate the treatment process. It was usually necessary to work with the mothers' reactions to separation as well (32). Often, it was essential to help the child differentiate his reaction from that of his mother and vice versa. For example, too often the depressed child was resonating with his parents' response or a projected expectation. The mothers frequently externalized their unresolved mourning to the child they brought to treatment.

SUMMARY

Forced military separations create clinically observable reactions in children. This long-term loss of the father is considered a developmental interference resulting in a disturbance in the typical unfolding of the child's personality.

The clinical data are taken from the psychiatric evaluation of children seen in a military child psychiatric clinic. A brief description of the clinic population is presented, based on an analysis of 100 patients.

The disturbances surrounding the temporary loss of the father cannot be separated from the crisis of reunion with the long-absent parent. The entire cycle of departure, interim, and reunion represents a continuum the child faces at critical times in his development regardless of his ego capacity to deal with the situation. Short-term reactions resembled reactions to other types of loss, especially divorce. Several areas of the child's development seemed particularly affected by the periodic cycle of events: superego formation, the capacity to tolerate depressive affect, and object relations.

Military separations create a cycle of events resulting in significant developmental interferences for children. An awareness of the emotional consequences of temporary separation from the father is important in treating these children.

REFERENCES

1. Lynn DB, Swarey WL: The effects of father-absence on Norwegian boys and girls. J Abnorm Soc Psychol 59:258–262, 1959
2. Gabower G: Problems of children in Navy officers' families. Social Casework 41:177–184, 1960
3. Dickerson WJ, Arthur RJ: Navy families in distress. Milit Med 130:894–898, 1965
4. Pederson FA: Relationship between father absence and emotional disturbance in male military dependents. Merrill-Palmer Quarterly 12:321–331, 1966
5. Baker SL, Fischer EG, Janda EJ, et al: Impact of father absence on personality factors in children (abstract). Am J Orthopsychiatry 37:269, 1967
6. Baker SL, Fischer EG, Cove LA, et al: Problems of family reintegration following prolonged father absence (abstract). Am J Orthopsychiatry 38:347, 1968
7. Gonzalez VR: Psychiatry and the Army Brat. Springfield, Ill, Charles C Thomas, 1970
8. Biller HB: Father absence and the personality development of the male child, in Annual Progress in Child Psychiatry and Child Development: 1971. Edited by Chess S, Thomas A. New York, Brunner/Mazel, 1971, pp 120–152
9. Kogelschatz JL, Adams PL, Tucker DM: Family styles of fatherless households. J Am Acad Child Psychiatry 11:365–383, 1972
10. McDermott JF, Harrison SI, Schrager J, et al: Social class and mental illness in children: observations of blue-collar families. Am J Orthopsychiatry 35:500–508, 1965
11. Ramsey-Klee DM, Eiduson B: A comparative study of two child guidance clinic populations. J Am Acad Child Psychiatry 8:493–516, 1969
12. Roach JL, Gurslin O, Hunt RG: Some social-psychological characteristics of a child guidance clinic caseload. J Consult Psychol 22:183–186, 1966
13. Bemporad JR, Pfeifer CM, Bloom W: Twelve months' experience with the GAP classification of childhood disorders. Am J Psychiatry 127:658–664, 1970
14. Kenny JA: The child in the military community. J Am Acad Child Psychiatry 6:51–53, 1967
15. Nagera H: Early Childhood Disturbances, the Infantile Neurosis and the Adult Disturbances. New York, International Universities Press, 1966
16. Gauthier Y: The mourning reaction of a ten-and-a-half-year-old boy. Psychoanal Study Child 20:481–494, 1965
17. Arthur B, Kemme ML: Bereavement in children. J Child Psychol Psychiatry 5:37–49, 1964
18. Wolfenstein M: Loss, rage and repetition. Psychoanal Study Child 24:432–460, 1969
19. Nagera H: Children's reactions to the death of important objects: developmental approach. Psychoanal Study Child 25:360–400, 1970
20. Keiser S: A manifest Oedipus complex in an adolescent girl. Psychoanal Study Child 8:99–107, 1953
21. Wylie HL, Delgado RA: A pattern of mother-son relationship involving the absence of father. Am J Orthopsychiatry 29:644–649, 1959
22. Neubauer PB: The one-parent child and his Oedipal development. Psychoanal Study Child 15:286–309, 1960
23. Despert L: Children of Divorce. Garden City, Dolphin Books, 1962
24. Trunnell TL: The absent father's children's emotional disturbances. Arch Gen Psychiatry 19:180–188, 1968
25. Westman JC, Cline DW, Swift WJ, et al: Role of child psychiatry in divorce. Arch Gen Psychiatry 23:416–420, 1970
26. McDermott JB: Divorce and its psychiatric sequelae in children. Arch Gen Psychiatry 23:421–427, 1970
27. Toolan JM: Depression in children and adolescents. Am J Orthopsychiatry 32:404–414, 1962
28. Burks H, Harrison S: Aggressive behavior as a means of avoiding depression. Am J Orthopsychiatry 32:416–422, 1962
29. Poznanski E, Zrull SP: Childhood depression—clinical characteristics of overtly depressed children. Arch Gen Psychiatry 23:8–15, 1970
30. Wolfenstein M: How is mourning possible? Psychoanal Study Child 21:93–126, 1966
31. Meiss ML: The Oedipal problem of a fatherless child. Psychoanal Study Child 7:216–299, 1952
32. MacIntosh H: Separation problem in military wives. Am J Psychiatry 125:260–265, 1968

The Life Course of Children with Schizophrenia

BY LAURETTA BENDER, M.D.

The background, hereditary data, history of organic stress, intellectual development, types of treatment received, and outcome are described for 100 children diagnosed as schizophrenics at Bellevue Hospital from 1935 to 1952. The author discusses the effects of various factors on the course of schizophrenia. About one-third of these 100 subjects, now 25 to 50 years of age, made a satisfactory adjustment to life in the community.

OF 6,500 CHILDREN observed at Bellevue Hospital from 1935 to 1952, 626 children (9.5 percent) were diagnosed as schizophrenics. Many have been the subjects of published reports and repeated follow-ups; 100 of them (now aged 25 to 50 years) are included in a current follow-up study (1). The diagnoses were made when the subjects were two and a half to 12 years of age; there were 80 boys and 20 girls. The age of onset for 32 subjects with autism was under two years of age, for 27 subjects with symbiosis it was two to three and a half years of age, for 28 it was in mid-childhood (three and a half to eight years of age), and for 13 it was in puberty (nine to 11 years of age). The outcome has revealed that 63 were chronically institutionalized (eight of these have died), while 37 are in the community in some sort of social adjustment.

In six cases, the diagnosis of schizophrenia has not been confirmed since childhood, though I believe that three of these were also schizophrenic as well as brain-damaged, encephalitic, and psychopathic. The other three were undoubtedly brain-damaged or had a congenital defect without schizophrenia.

Ninety-four of the subjects have been recognized as schizophrenic in institutions or by social agencies or therapists. As adults, their schizophrenia has taken such forms as withdrawn autistic states, many with organic complication; disturbed catatonic, paranoid, and unclassified schizophrenics in state institutions; and pseudopsychopathic (sometimes in correctional institutions), pseudoneurotic, ambulatory, or remitted schizophrenics in the community.

Read at a New Research session at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Bender is Professor of Clinical Psychiatry, College of Physicians and Surgeons, Columbia University, and Attending Psychiatrist, New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032.

CULTURAL BACKGROUND, FAMILY PATTERN, AND HEREDITY

The studies of cultural, socioeconomic, ethnic background and family patterns did not confirm any of the theories of an environmental factor in the etiology (such as schizophrenogenic, "refrigerator," highly intelligent, or depriving parents) in a sufficient number of cases, though there were examples of all of these. Every kind of home was represented. The cultural pattern reflected the social situation in New York in the 1930s and 1940s, as well as the ability of concerned parents and agencies to find help for these deviant children.

Social studies of early family life did indicate determinants that appeared to be related to the type of defenses that some of the more capable were able to make in adolescence, whether they were pseudopsychopathic or pseudoneurotic, and whether the ultimate adjustment was one of antisocial turmoil or passive dependency (2). There was a significant family pattern reflecting the degree of pathology in the parents and suggesting the kinds of homes from which children might be referred and to which they might be returned. However, it did not seem to influence the etiology or the adult outcome.

The data on heredity (table 1) show 215 mentally ill relatives; 86 were psychotic and 129 had personality disorders sufficiently severe to require social or medical attention. Recent researchers (3–5) have referred to these as the schizoid part of the "schizophrenic continuum." For this group of 100 patients, schizophrenic from childhood, 17 subjects had 24 psychotic siblings and 17 had 24 personality-disordered siblings (some patients had more than one mentally ill sibling) for a total of 34 percent. There were also 15 psychotic mothers and 25 mothers with personality disorders (40 percent) and seven psychotic fathers and 36 fathers with personality disorders (43 percent). The recent genetic studies accept Kallmann's estimate cited in Heston (5, pp. 252–253) of 45 percent of each class of first-degree relatives as being in the "schizophrenic spectrum." It is emphasized that polygenic and diasthetic stress theories are probably acceptable since it is felt that, although genetic factors are necessary, other, probably environmental, factors are important in the etiology of schizophrenia.

ORGANIC STRESS IN CHILDHOOD

In childhood schizophrenia, I have found the stress or environmental factor to be an organic one occurring in

TABLE 1
Data on Heredity of 100 Schizophrenic Children

Category	Number	Siblings		Mother		Father		Collateral Relatives	
		Psychotic	Personality Disorder	Psychotic	Personality Disorder	Psychotic	Personality Disorder	Psychotic	Personality Disorder
Infantile autism	32	7	5	3	9	2	5	12	15
Symbiotic syndrome	27	3	4	6	5	3	14	22	18
Onset in childhood	28	11	11	5	6	0	9	3	5
Onset in puberty	13	3	4	1	5	2	8	3	6
Total	100	24	24	15	25	7	36	40	44

utero, perinatally, or in early childhood (see table 2). Of the 50 children of this type with the earliest onset, 34 percent had organic disorders that dominated the clinical picture throughout life in addition to their schizophrenia; none of these could be kept out of an institution. An additional 42 percent had perinatal pathology in their histories that was seen as precipitating the schizophrenic decompensation; eight of these made a dependent social adjustment in adulthood. This accounts for 76 percent of the early autistic schizophrenics with decompensating organic factors. Eight also had convulsions in childhood or adolescence and eight died between the ages of 22 and 44 of convulsions or inadequate cardiac and visceral functions.

Of the 50 children whose onset was after infancy and without autism, there were three with organicity that dominated their life pattern, 46 percent with perinatal pathology precipitating the childhood schizophrenia, and an additional six who showed pathology after five years of age but before the onset of their schizophrenia. Of these 50, 19 made a social adjustment as adults and three had convulsions, one of whom ultimately died as a result.

Thus 70 percent of the total group had histories or clinical evidence of organicity affecting the brain that accounted for the onset of an early schizophrenic decompensation. There were still 30 percent about whom we had no history or clinical evidence of organicity but who ran a similar course of schizophrenia. Our histories were undoubtedly inadequate and it may be that factors in early development and a reported uncomplicated birth might have been stressful in some very vulnerable cases.

The characteristic features of the young schizophrenic child are seen in the primitive plasticity, the maturational lags, and the neurophysiological disorganization, especially as noted in the research of Barbara Fish (6).

INTELLECTUAL DEVELOPMENT

Some interesting data have come from the psychometric tests that were repeated frequently for many of these subjects from early childhood to adulthood. Of the 37 who made a social adjustment as adults only two as small children with autism were ever untestable on one test each, and only three others scored below 50 percent on IQ tests at some time in their lives. These five and all others have tended to develop intelligence between the IQ levels of 70 and 100 through most of their life. Six have demonstrated superior intelligence on tests and three have acquired college degrees.

There was a tendency for a remarkable stability of IQs over the life span in these schizophrenic individuals, while at the same time there was variability between verbal and performance scores and an intertest variability. The verbal scores were usually higher. There was no evidence of deterioration due to schizophrenia. Some patients were

TABLE 2
Organic Factors in Schizophrenia of 100 Children and Later Social Adjustment

Category	Onset in Infancy With Autism		Onset in Childhood Without Autism		Total	
	Number	Social Adjustment	Number	Social Adjustment	Number	Social Adjustment
Organic disorders throughout life	17	0	3	0	20	0
Precipitating perinatal pathology	21	8	23	16	44	24
Precipitating pathology after age 5	0	0	6	3	6	3
No history of perinatal pathology	12	4	18	6	30	10
Total	50	12	50	25	100	37
Chronically institutionalized	38		25		63	
Died	7		1		8	

Psychotic	Total Personality Disorder	Total Mentally Ill Relatives	Mentally Ill Relatives Per Patient	Family Histories Negative
24	34	58	1.8	8
34	41	75	2.7	2
19	31	50	1.7	5
9	23	32	2.1	0
86	129	215	2.15	15

out of contact and untestable for years, as adults, but if they came in contact again, some because of the recent use of psychoactive drugs, they again achieved IQ scores in the normal range, comparable to their functioning in childhood or adolescence, on a variety of tests. However, reality testing and ability to function independently were often not commensurate with their verbal intelligence scores.

In general those 63 subjects who have become chronically institutionalized have had low intelligence scores. None maintained above-average scores and the majority clustered around the borderline level. Those children who were most autistic—lacking in language development and untestable on psychometric tests—tended to remain at that low level. Variability in testing was shown in these subjects, as it was in the subjects with higher IQ and better adjustment. Drops in IQ occurred when patients dropped out of contact or when there was an organic deterioration, especially when it led eventually to death. Most impressively, there was a tendency for IQs to rise moderately, especially in adulthood, even for those subjects who were in institutions. Recent drug therapy may have contributed to this.

TREATMENT

As children at Bellevue, these subjects had every form of treatment then available. This included individual psychoanalysis, group psychotherapy, activity programs with schooling, individual tutoring, music, art, dance, and puppetry. We used the drugs then available: anticonvulsants, amphetamines, and barbiturates. Some of these treatments at the time seemed to ameliorate anxiety and disorganization, stimulate maturational lags, strengthen neurotic defenses, and make the children more available for specialized care and educational programs.

We also used metrazol and electric convulsive treatment and an attempt has been made to evaluate the results (7). Twenty-eight subjects had metrazol convulsive treatment (MeCT), 59 had electroconvulsive treatment (ECT), and 13 had no convulsive treatment. Of the 20 girls, only two made a social adjustment, one who had ECT and one who had no convulsive treatment, and apparently only after receiving psychoactive drugs as adults. I will therefore evaluate only the boys below; Kalinowsky (8) has said that there is no difference between men and women in their response to convulsive therapy.

Of the boys who did not have convulsive treatment, 30 percent made a social adjustment, while 54 percent of those treated with MeCT and 40 percent treated with ECT became socially adjusted; see table 3. A review of the international literature (9) on follow-up studies of children with schizophrenia or allied conditions showed that 31.5 percent were able to make an adequate adjustment in adulthood or adolescence. In these studies the boys and girls were not separated.

Our clinical impression was that convulsive therapy improved the general clinical and behavioral adjustment of many schizophrenic children. Most significantly it brought to light the natural history of remissions, which often occur spontaneously in boys during puberty (age ten and a half years through adolescence) and in girls during latency (age eight years through puberty). Such remissions may be facilitated if the convulsive therapy is given at such a time that it may anticipate a remission or within one to two years after an acute onset or after an exacerbation during puberty. Such periods of remission can be used to educate or treat the patient in the community even though a recurrence sends the patient back to the hospital later.

After the children left Bellevue, various ones were subjected to every new form of therapy that became available. The only significant results were seen in 16 subjects (including two women) who left the hospital and became socially adjusted after they were adults (late 20s, in most cases) and after they had received the psychoactive drugs and socializing program that was developed in the New York State hospital system in the mid-1950s.

CONCLUSIONS

Childhood schizophrenia, including autism, is an early decompensation in a genetically vulnerable individual due to organic stress in utero, perinatally, or in early childhood. It lasts throughout the person's life, with a variety of clinical features during different life epochs and

TABLE 3
Convulsive Therapy in Childhood of 80 Boys and Later Social Adjustment

Category	Number	Social Adjustment Number	Social Adjustment Percent	Chronically Institutionalized Number	Chronically Institutionalized Percent
No convulsive therapy	10	3	30	7	70
Metrazol convulsive therapy	26	14	54	12	46
Electroconvulsive therapy	44	18	40	26	60
Total	80	35	44	45	56

perhaps dominated by the original decompensating organic condition. Remissions in affected children often occur spontaneously at puberty in boys and during latency in girls. Convulsive therapy may facilitate such remissions. Otherwise there is a favorable prognosis for about one-third of the cases studied to make a social but vulnerable and dependent adjustment in the community. Treatment with psychoactive drugs and energetic socializing programs, even in adulthood, may increase the number who make a social adjustment. Many other treatment measures may stimulate maturational lags during development and help to establish coping mechanisms in episodes of decompensation.

REFERENCES

1. Bender L: The life course of schizophrenic children. Biol Psychiatry 2:165–172, 1970
2. Bender L: Psychopathic personality of schizophrenia in adolescence. Biol Psychiatry 3:197–204, 1971
3. Rosenthal D: Genetic research in the schizophrenic syndrome, in The Schizophrenic Reaction. Edited by Cancro R. New York, Brunner/Mazel, 1970, pp 245–258
4. Kety SS: Genetic environment interaction in the schizophrenic syndrome. Ibid, pp 233–244
5. Heston LL: The genetics of schizophrenic and schizoid disease. Science 167:249–255, 1970
6. Fish B: Contributions of developmental research to a theory of schizophrenia, in Exceptional Infant, Vol 2: Studies in Abnormalities. Edited by Helmuth J. New York, Brunner/Mazel, 1971, pp 473-482
7. Bender L: Long-term results of convulsive therapy of schizophrenic children. Read at the 1971 meeting of the Society of Biological Psychiatry, Washington, DC, April 30–May 2, 1971
8. Kalinowsky LT: Effects of somatic treatment on the clinical course, psychopathological and pathophysiological research in schizophrenia, in Psychopathology of Schizophrenia. Edited by Hoch P, Zubin J. New York, Grune & Stratton, 1966, pp 412–424
9. Bender L: Discussion of "Prognosis of infantile psychosis and neurosis," in Proceedings of the Fourth World Congress of Psychiatry, Madrid, 5–11 September, 1966. Edited by López Ibor JJ. Amsterdam, Excerpta Medica Foundation, 1967, pp 124–126

Later Psychosocial Sequelae of Early Childhood Illness (Severe Croup)

BY J.J. SIGAL, PH.D., L. CHAGOYA, M.D., C. VILLENEUVE, M.D., AND J. MAYEROVITCH, M.A.

Twelve families in which only one child had had severe croup before the age of five were examined several years later. Parents rated the behavior of the proband and one of his siblings separately, and each child rated his parents' attitudes toward him. The data confirm that severe early childhood illness results in later disturbances in the parent-child relationship, and they permit a clear description of the "vulnerable child syndrome."

GREEN AND SOLNIT (1) have hypothesized that children whose parents expect them to die prematurely may react with disturbances in psychosocial development. They labeled the parent-child interaction in which such disturbances appear "the vulnerable child syndrome." A severe, acute illness in a young child evokes fears in the parents that the child might die. If Green and Solnit's hypothesis is true, such children should be more disturbed than their siblings. Furthermore, study of such families could help delineate the elements in the parent-child interaction that produce the vulnerable child syndrome.

There are few studies that deal with the later psychological effects of an acute illness early in life, and they yield contradictory results. In two, an interaction effect is reported between parental concern and child behavior (1, 2). In a third, the only one in which a control group was used, such an effect was not demonstrated (3). Because of certain defects in their design, no firm conclusions can be drawn from these studies concerning groups for which the hypothesis of the vulnerable child syndrome might be

At the time this work was done, the authors were with the Jewish General Hospital, Montreal 249, Quebec, Canada, where Dr. Sigal is Research Director, Institute of Community and Family Psychiatry; he is also Associate Professor, Department of Psychiatry, McGill University. Currently, Dr. Chagoya is Psychiatric Consultant, Adolescent Service, Hospital Infantil de Mexico, and Assistant Professor, Universidad Ibero-Americana, Mexico City, Mexico. Dr. Villeneuve is Staff Psychiatrist, Hôpital Rivière-des-Prairies, Montreal. Ms. Mayerovitch is Psychologist, Laval School Board, Laval, Quebec, Canada. Address reprint requests to Dr. Sigal, Jewish General Hospital.

The authors wish to thank the staffs of Montreal Children's Hospital, Royal Victoria Hospital, St. Mary's Hospital, Hôpital Notre Dame, and Hôpital Sainte Justine for their cooperation in making their records available.

TABLE 1
Major Reason for Referral

Reason	Number	Percentage
Symptom of unknown etiology (possibly psychosomatic)	24	30
Question of depression	15	19
Behavior problem on ward	10	13
Specific symptom problem*	8	10
Parent with psychiatric problem	7	9
Acute psychosis	4	5
Other**	11	14

*Enuresis (one patient), hyperactivity (two), obesity (one), anorexia (two), pruritus (one), and aerophagia (one).
**Suicide attempt (three patients), battered child (one), preoperative evaluation (two), disfigurement (one), self-mutilation (one), retarded social skills (one), and precocious puberty (two).

TABLE 2
Psychiatric Diagnoses of Patients

Diagnosis	Number	Percentage
Hysteria	15	18.9
Hyperactive child syndrome	10	12.6
Depression	7	8.9
Organic brain syndrome	7	8.9
Mental retardation	4	5.1
Other personality disorders	4	5.1
Anorexia nervosa	3	3.8
Anxiety neurosis	2	2.5
Sociopathy	2	2.5
Enuresis/encopresis	1	1.3
No psychiatric illness	15	18.9
Undiagnosed psychiatric illness*	9	11.5

*Psychiatric symptoms not clearly classifiable into the above categories.

cial adjustment but did not match a specific psychiatric diagnosis.

RESULTS AND DISCUSSION

Seventy-nine patients were referred for psychiatric evaluation, or just over one percent of the 6,041 patients who were admitted during the 11-month period from July 1, 1971, to May 30, 1972. (The reported rates for consultation on adult medical and surgical wards range from one to ten percent [3].) The patients referred were kept in the hospital an average of five days longer than other patients (13.8 vs. 8.1 days); their ages ranged from two years up to the hospital limit of 15 years (mean = 10.7 ± 3.7 years). Fifty-three percent were girls, a proportion that was higher than the percentage of girls in the general patient population (44 percent).

Sixty percent of the referrals came from the general pediatrics service, with the remainder evenly divided between the neurologic and the surgical services. The presenting problem concerned the nervous system in 33 percent of the patients, the gastrointestinal system in 22 percent, the endocrine system in 15 percent, and other systems in 30 percent. At the time of discharge 60 percent of the patients had a medical or surgical diagnosis, but no physical cause had been identified to account for the complaints of the other 40 percent.

The primary physician's reason for requesting a consultation (table 1) correlated with the psychiatric diagnosis we made on the child. When a child was referred for a behavior problem on the ward, he was more likely to be a hyperactive child than to have any other condition ($\chi^2 = 5.2$, d.f. = 1, $p < .05$). Referrals for "symptoms of unknown origin, possibly psychosomatic" were associated with the diagnosis of hysteria ($\chi^2 = 13.7$, d.f. = 1, $p < .001$), and referrals for "question of depression" were, not surprisingly, associated with the diagnosis of affective disorder ($\chi^2 = 17.7$, d.f. = 1, $p < .001$).

Hysteria was the most common psychiatric disorder found on consultation (table 2); one-third of the girls (ranging in age from nine to 14) had this diagnosis. This finding suggests that hysteria is more common among children than would appear from the work of Robins and O'Neal (4). Depression was a relatively common diagnosis; two of the seven patients in this group had a fatal illness. Half of the children in the "no psychiatric illness" category were referred to us because one of their parents (the mother in all cases) had a problem.

A number of the children, mainly those who were hyperactive, had a history of previous psychiatric care (11 percent) and of learning problems (35 percent). The prevalence of psychiatric disorders among the parents (29 percent of the mothers and 28 percent of the fathers) was higher than the corresponding figures (15 percent and 17 percent, respectively) for the parents of a series of normal children in the same hospital (5), but the rate in the mothers of our patients was inflated by those whose problems were the reason for the referral. Three-fourths of the mothers who had psychiatric disorders were diagnosed as having a depression. Half of the affected fathers were diagnosed as alcoholic and one-fourth as sociopathic.

We arranged for 40 percent of the children to have outpatient psychiatric treatment after their discharge; nine percent of the children were started on psychotropic medications; none required transfer to a psychiatric hospital.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968
2. Feighner JP, Robins E, Guze SB, et al: Diagnostic criteria for use in psychiatric research. Arch Gen Psychiatry 26:57–62, 1972
3. Anstee BH: The pattern of psychiatric referrals in a general hospital. Br J Psychiatry 120:631–634, 1972
4. Robins E, O'Neal P: Clinical features of hysteria in children. Nerv Child 10:246–271, 1953
5. Morrison JR, Stewart MA: A family study of the hyperactive child syndrome. Biol Psychiatry 3:189–195, 1971

REFERENCES

1. Green M, Solnit A: Reactions to the threatened loss of a child: a vulnerable child syndrome: pediatric management of the dying child, part III. Pediatrics 34:58–66, 1964
2. Gibson R: Trauma in early infancy and later personality development. Psychosom Med 27:229–237, 1965
3. Costanza M, Lipsitch I, Charney E: The vulnerable child revisited: a follow-up study of children three to six years after acute illness in infancy. Clin Pediatr 7:680–683, 1968
4. Sigal JJ, Chagoya L, Villeneuve C, et al: Later psychological consequences of near-fatal illness (nephrosis) in early childhood: some preliminary findings. Laval Med 42:103–108, 1971
5. Hollingshead AB, Redlich FC: Social Class and Mental Illness. New York, John Wiley & Sons, 1958
6. Schaefer ES: Children's report of parental behavior: an inventory. Child Dev 36:413–424, 1965
7. Peterson D: Behavior problems in middle childhood. J Consult Psychol 25:205–209, 1961
8. Richards TW, Simons MP: The Fels child behavior scales. Genet Psychol Monogr 24:259–309, 1941
9. MacFarlane JW: Studies in child guidance, I: methodology of data collection and organization. Monogr Soc Res Child Dev 3 (No 6, Serial No 19):1–70, 1938
10. Glidewell JH, Mensh RI, Gildea MC-L: Behavior symptoms in children and degree of sickness. Am J Orthopsychiatry 114:47–53, 1957
11. Freud A: The role of bodily illness in the mental life of children. Psychoanal Study Child 7:69–81, 1952
12. Sigal JJ: Some familial consequences of maternal preoccupation. Read at the 7th annual meeting of the Quebec Psychiatric Association, Montreal, April 17–18, 1970
13. Sigal JJ: Familial consequences of parental preoccupation. Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex, May 1–5, 1972

Psychiatric Consultations in a Children's Hospital

BY EDWARD P. MONNELLY, M.D., BENJAMIN M. IANZITO, M.D., AND MARK A. STEWART, M.D.

The psychiatric consultations done in a children's hospital over an 11-month period were analyzed. Major reasons for referral included a symptom of unknown etiology (possibly psychosomatic), suspected depression, and behavior problems on the ward. Hysteria was the most common psychiatric disorder found on consultation; one-third of the girls had this diagnosis. The other most frequent diagnoses were hyperactive child syndrome, depression, and organic brain syndrome.

CHILDREN ADMITTED to the hospital for medical or surgical reasons sometimes present psychiatric problems, but this interesting field seems to have been neglected by researchers. We were unable to find a systematic study of psychiatric consultations on patients in a children's hospital in our search of the literature. In this paper we present data on the kinds of psychiatric problems that lead to consultation and their relative frequency.

At the time this work was done, the authors were with Washington University School of Medicine, St. Louis, Mo. Dr. Monnelly is now Staff Psychiatrist, Veterans Administration Outpatient Clinic, 17 Court St., Boston, Mass. 02108. Dr. Ianzito is Chief Psychiatrist, USAF Regional Hospital, Chanute Air Force Base, Rantoul, Ill.; and Dr. Stewart is Ida P. Haller Professor of Child Psychiatry, University of Iowa College of Medicine, Iowa City, Iowa.

This work was supported in part by Public Health Service grant MH-05804 from the National Institute of Mental Health.

METHOD

The study involved all patients referred for psychiatric consultation during an 11-month period by the attending staff and house officers of St. Louis Children's Hospital, which has 165 beds and is part of the Washington University Medical Center. We interviewed all children within 48 hours of referral, using a standardized form that covered the child's medical, developmental, and school history, his family life, and a review of psychological symptoms. The parents were also interviewed about the child's history and symptoms and their own psychiatric history. Information was obtained from the referring doctor and occasionally from other family members, the child's teachers, and social workers.

The diagnostic criteria for the children generally followed the definitions in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) (1), while diagnoses for the parents were based on the criteria of Feighner and associates (2). The diagnosis of hysteria in children was based on the latter criteria, but we required only 18 symptoms in eight categories, and only 16 for a diagnosis of probable hysteria. The children who were diagnosed as having other personality disorders had histories that showed poor so-

could answer on a three-point scale. The parents completed each scale jointly, once for the proband and once for the sibling.

RESULTS

The two-tailed t test for differences (11 degrees of freedom) was used for all statistical comparisons.

The following is a list of attitudes that probands saw in their parents significantly more often than did their siblings:

1. Mother shows positive involvement with them ($t = 2.57$, $p < .05$) but exerts psychological control ($t = 2.59$, $p < .05$), is intrusive ($t = 3.21$, $p < .01$), instills persistent anxiety ($t = 2.32$, $p < .05$), does not enforce rules ($t = 4.02$, $p < .01$), does not foster independence ($t = 3.38$, $p < .01$), and sets high standards ($t = 2.38$, $p < .05$).
2. Father is intrusive ($t = 2.36$, $p < .05$) and exerts hostile control ($t = 2.37$, $p < .05$).

The following is a list of attitudes that the probands saw in their parents more often than did their siblings, to a degree approaching statistical significance:

1. Mother sets limits ($t = 2.04$, $.10 > p > .05$).
2. Father exerts psychological control ($t = 1.91$, $.10 > p > .05$), does not foster independence ($t = 2.11$, $.10 > p > .05$), sets limits ($t = 1.80$, $.10 > p > .05$), sets high standards ($t = 2.13$, $.10 > p > .05$), and also sets low standards ($t = 2.13$, $.10 > p > .05$).

When the parents compared the proband with his sibling, they reported more of the following behavior in the former: conduct problems ($t = 2.24$, $p < .05$), excessive dependence ($t = 2.91$, $p < .02$), and testing of limits ($t = 2.43$, $p < .05$). The parents also perceived the siblings as curbing their aggression more than the probands ($t = 2.27$, $p < .05$).

At a level that approached significance, the parents perceived the probands as having a lower level of personal functioning than that of the siblings ($t = 1.89$, $.10 > p > .05$). There were no other statistically significant differences.

DISCUSSION

Since there was a sex and age difference between our two groups, we are not able to determine with certainty whether some of the children's or parents' perceptions were due to the age difference between probands and siblings or to consequences of the past illness in the child. A larger sample could not be obtained, and a nonsibling control group matched for age and sex would have introduced other methodological problems. However, the consistency of the results in this study and our previous one (4) and zero-order correlations of the dependent variables with age and sex suggest that age and sex differences are probably not responsible for the differences obtained.

Results on the Child Behavior Inventory only indirectly test our hypotheses about the children's behavior, since we did not use direct observation. Work by Glidewell and associates (10), however, suggests that mothers accurately reply to questionnaires dealing with children's problems. It could also be argued that the children's reports on the Child Report of Parental Behavior Inventory do not necessarily give a true picture of parental behavior. Nonetheless, they do reveal how the children perceive their psychosocial context (parental behavior). An inspection of differences can, therefore, be used to test and render more explicit Green and Solnit's description of the vulnerable child syndrome and, in the absence of observational data of proven reliability, provide the best means of testing our hypotheses.

We have confirmed all hypotheses concerning the areas and direction of the probands' deviant behavior when compared with that of their siblings. We have also confirmed most of the hypotheses concerning the parents' behavior. Worthy of note are those areas in which the results of the present study are consistent with those of our study of the later functioning of families in which one child had had nephrosis in his earlier years (4). In both studies the probands had more conduct problems and a greater degree of psychological disturbance (as measured by their score on overall level of performance) than their siblings. There were no differences in either study between the two children in their feelings of acceptance or rejection or in the rigidity of control by their parents. In both studies the formerly ill children, more than their siblings, perceived both parents as exerting more psychological control; specifically, they saw both parents as exercising more hostile control and mothers, but not fathers, as controlling through guilt and instilling persistent anxiety.

Of particular interest, and contrary to our hypotheses, are the probands' reports, relative to their siblings, that their parents exercise more psychological control over them and set more limits on them. Assuming that these reports are valid, one explanation might be that the parents attempt, too late, to control behavior that was initially elicited by the inadequate controls and the inadequate limit setting often found in parents' relationships to children who are ill. Guilt, identification with a child, fear of loss, etc., have long been known to be the basis for failure in control when the child is ill (11). Sigal (12, 13) has suggested that parental identification with the child's aggressive behavior and continued parental preoccupation with the possibility of loss of the child may result in less effective psychological control of the probands than of the siblings, despite the greater incidence of attempts to control the former. On inspecting our data, we find support for the impression that parental preoccupation plays an important role in determining the behavior of the children, since the highest differences in parental attitudes toward probands and siblings occurred in instances in which the probands had had a tracheotomy; it was in these cases that, according to our coded, structured interviews, the parents reported the greatest concern about the survival of the child at the time of the illness.

valid. None of them presents material in a way that permits statistical validation. All fail to examine the reactions of either the father or the siblings, important elements in the psychosocial environment. Finally, the two systematic attempts (2, 3) to verify the original hypothesis derived by Green and Solnit from clinical observation did not deal with children beyond the age of eight, when the child's adaptation to peers and to the school setting takes on a greater significance and when the feedback from the school becomes an important element in the parents' perception of the child's behavior.

The present study is an attempt to overcome some of these defects.

The hypotheses that we propose to test are based on clinical observations of families in which one child had a severe illness some years prior to the study. They are as follows: When a child has been severely ill in early childhood, the parents will present any combination of: 1) failure to foster independence in the child, 2) trouble in controlling the aggressive acts of the child, 3) inability to set limits on the personal habits of the child, and 4) low expectations of the child's general performance. The child, in response to this, will present any combination of: 1) failure to strive for independence, 2) difficulty in curbing his own aggression, 3) testing the limits that parents set, and 4) a low level of personal functioning.

This is the second in a series of studies designed to test these hypotheses. In a previous paper (4) we dealt with families in which one child was healthy and one child had suffered from acute nephrosis sometime between the ages of two and five and had completely recovered from the illness at the time of the study, when he was seven to 12 years old. These children reported that their parents had more of the following attitudes toward the post-nephrotic child than toward his sibling: 1) failure to foster independence; 2) attempts to control by guilt, hostility, and by instilling persistent anxiety; and 3) inconsistency in the way they applied discipline. According to the parents, the child who had been physically ill, when compared with his sibling, had a tendency to present more conduct problems and to have a lower level of personal functioning. In that paper, parental preoccupation was postulated as the underlying cause of these difficulties.

It is possible that the conduct problems found in the preceding study were due to the effect of steroids, which are commonly used for the treatment of nephrosis and are known to affect behavior. In order to rule out medication as the determining factor, we decided to extend the study to a group of children who had been severely ill but had not received steroid medication.[1] Therefore, we continued the study of the psychosocial sequelae of early childhood illness by examining the behavior of families in which a child had had acute, severe croup. One long hospitalization, repeated short stays in the hospital, or a tracheotomy were assumed to indicate that the illness had been severe.

[1] We wish to thank Dr. R. Feldman for suggesting this group to us. He had observed that children with acute laryngotracheitis or croup also produced an intense preoccupation in the parents.

METHOD

Sample

We reviewed all of the approximately 600 charts that might have provided subjects for our study in the two pediatric hospitals and in two general hospitals of a large metropolitan area. Only 12 of these charts led us to families who were appropriate and available for the study. A large number of families could not be reached because they had moved and could not be traced. A smaller number were not included in this study for one of the following reasons: they refused to participate, there was no sibling of the right age, the sibling had been severely ill in early childhood, the proband had one or more other severe illnesses, or there was only one parent in the home.

The characteristics of the final sample were as follows. In each family there was a child, the proband, who had suffered from severe croup, which had required a tracheotomy and one or two hospitalizations (mean duration = 10.8 days, range = two to 31 days). Seven probands were hospitalized twice and five, once. The probands had been sick between the ages of two and five, had recovered completely, and had not suffered any serious disease since then. At the time of the interview the probands ranged in age from seven to 11 years (mean age = 8.6). Each proband had a sibling whose age ranged from seven to 12 years (mean age = 10.4) and who had always been in good health. He served as the control. Ten of the probands were boys and two were girls. Four of the controls were boys and eight were girls. In six families the proband and the control were of the same sex, and in the other six they were of different sex. Nine of the controls were older than the proband and two were younger. The sample included one set of twins. The average age difference between probands and controls was 1.8 years, which is statistically significant ($t = 1.56$, d.f. = 11, $p < .05$).

The families were middle class, ranging from categories 2 to 6 (mean level = 4), according to the Hollingshead and Redlich (5) classification of employment of the head of the household. All of the families lived in the Montreal area. Six were English-speaking and six were French-speaking.

Procedure

The children rated their parents' behavior using Schaefer's Child Report of Parental Behavior Inventory (6). The proband and the sibling answered independently, once for their mother and once for their father. For scoring purposes, the items of this scale were grouped into Schaefer's categories and also into categories that referred directly to our hypotheses (see Sigal and associates' study [4] for details).

The parents' perception of their children's behavior was obtained by having them complete Quay and Peterson's Behavior Problem Checklist (7) and the Sigal-Chagoya Child Behavior Inventory (4). The latter consists of items selected from the Fels Child Behavior Scales (8) and the MacFarlane Child Behavior Inventory (9), rewritten and modified so that the parents

Evidence for Polygenetic Inheritance in the Hyperactive Child Syndrome

BY JAMES R. MORRISON, M.D., AND MARK A. STEWART, M.D.

Patients with hyperactive child syndrome frequently have relatives who were hyperactive as children or who are alcoholic adults. In their study the authors found that the distribution of these conditions in the families of 59 hyperactive children supports a polygenetic mode of inheritance.

IN A PREVIOUS COMMUNICATION (1) we demonstrated that there is an association between the hyperactive child syndrome and certain character disorders such as hysteria, sociopathy, and alcoholism. Legal families of adopted hyperactive children do not have a high prevalence of such disorders (2), providing evidence that these relationships may be, at least in part, genetically determined. Such a genetic factor could be either a major gene or the summation of a number of genes to produce the clinical syndrome of the hyperactive child. One aspect of the polygenetic hypothesis is that the greater the number of individuals in the family who are affected, the higher the risk component in that family. Thus, if hyperactivity is linked with alcoholism, for example, families in which there is more than one case of hyperactivity would have a higher prevalence of alcoholism than families that have only one case of hyperactivity. To test the hypothesis of polygenetic transmission, we have reexamined the data obtained from our previous study.

METHOD AND RESULTS

All of the available natural parents of 59 children diagnosed as hyperactive (3) were interviewed by one of us, who inquired about secondary cases of the hyperactive child syndrome and alcoholism. The interviewer knew that all of the subjects were hyperactive, and he conducted the interviews with no hypothesis in mind regarding possible modes of transmission, so that interviewer bias cannot be said to have influenced the outcome of this study.

The data from 26 families with more than one case of hyperactivity in the immediate or extended families of the proband and the 33 families with no such secondary cases are included in table 1, which compares the prevalence of alcoholism in the two groups of families. The prevalence of alcoholism in first- and second-degree relatives is nearly twice as high in the families with secondary cases of hyperactivity as in the families with no secondary cases ($z = 2.24$, $p < .05$, two-tailed t test).

The greater prevalence of alcoholism in families with two cases of hyperactivity suggests a "dose-response" association between the two illnesses. These results are consistent with a multifactorial or polygenetic hypothesis for the inheritance of the two conditions.

Following the polygenetic theory of inheritance, families of probands who have a first-degree relative also affected with hyperactivity may be presumed to have a higher "dose" of the genes responsible, so they would be more likely to have remote relatives so affected. We found that of the families with an affected first-degree relative, seven had an extended relative who was affected, and eight did not. Of the families that did not have an affected first-degree relative, eight had an extended relative who was affected, and 36 did not. Thus probands who had an affected parent or sibling were in fact more likely to have a cousin, aunt, or uncle who was similarly affected ($z = 2.24$, $p < .05$).

DISCUSSION

Such data alone cannot be construed as supporting either a genetic or environmental mode of transmission; other studies recently reported do provide evidence of this type, however. Safer (4), in a study of sibs and half-sibs of children with minimal brain dysfunction (MBD) who had been reared in foster homes, found that significantly more sibs than half-sibs showed signs of the disorder, which is consistent with a theory of genetic transmission. In a recent study (2) we have shown that the foster parents of hyperactive children adopted shortly after birth did not manifest the same amount and type of psychopathology as did the natural parents. Thus, all available evidence points to a genetic factor in the transmission of this syndrome.

Information as to the type of transmission is sparse and contradictory. Two studies have linked childhood behavior disorders with specific dyslexia. Hallgren (5) found that 58 percent of clinic patients with dyslexia were problem children, and he presented data supporting an autosomal dominant mode of inheritance. Frisk and associates (6) noted that 95 percent of teen-age dyslexics had emotional disturbances such as restlessness and distractibility, but they postulated an X-linked transmission.

At the time this work was done, the authors were with the Department of Psychiatry, Washington University School of Medicine, St. Louis, Mo. Dr. Morrison is currently Assistant Professor of Psychiatry, School of Medicine, University of California at San Diego, Calif. Dr. Stewart is Professor of Psychiatry, University of Iowa, Iowa City. Address reprint requests to Dr. Morrison at Veterans Administration Hospital, 3350 La Jolla Village Dr., San Diego, Calif. 92161.

TABLE 1
Prevalence of Alcoholism in Relatives of Families With and Without Secondary Cases of Hyperactivity

Category	Families	Relatives	Alcoholic Relatives	
			Number	Percentage
Secondary case	26	270	30	11.1
No secondary case	33	349	20	5.7

Wender (7) cited the fact that MBD does not "breed true" as supporting a theory of polygenetic transmission and postulated that genes controlling attentiveness and motor activity occupy separate chromosomal loci and therefore vary independently of one another. While the data from the present study do not rule out other modes of transmission, they support the polygenetic transmission model.

Carter (8) has suggested other consequences of the polygenetic hypothesis that are testable in the hyperactive child syndrome, namely, with more severely ill index cases there should be more ill relatives, and girls, being less frequently affected, should have more affected relatives. Because we lacked objective, quantifiable means of determining the severity of the index cases in our present population, we could not test the first proposition. Because of the paucity of female probands, we were not able to evaluate the second proposition. Both are testable, however, and should be examined in the future by persons investigating the hyperactive child syndrome.

REFERENCES

1. Morrison JR, Stewart MA: A family study of the hyperactive child syndrome. Biol Psychiatry 3: 189–195, 1971
2. Morrison JR, Stewart MA: The psychiatric status of the legal families of adopted hyperactive children. Arch Gen Psychiatry (in press)
3. Stewart MA, Pitts FN Jr, Craig AG, et al: The hyperactive child syndrome. Am J Orthopsychiatry 36: 861–867, 1966
4. Safer D, cited in Wender P: The minimal brain dysfunction syndrome in children. J Nerv Ment Dis 155: 55–71, 1972
5. Hallgren B: Specific dyslexia. Acta Psychiatr Neurol (suppl 65:1–287), 1950
6. Frisk M, Wegelius E, Tenhunen T, et al: The problem of dyslexia in teenage. Acta Paediatr Scand 56: 333–343, 1967
7. Wender PH: Minimal Brain Dysfunction in Children. New York, John Wiley & Sons, 1971
8. Carter CO: Multifactorial genetic disease. Hospital Practice 5: 45–49, 55–59, 1970

Video Feedback in Treating Hyperkinetic Children: A Preliminary Report

BY SEYMOUR FURMAN, M.D., AND ANNE FEIGHNER, M.S.W.

The authors added sessions of videotape feedback to a treatment program for hyperkinetic children that originally also employed chemotherapy and parental group counseling. Parent-child interactions were videotaped and immediately replayed to the parents and therapists alone. During these sessions, the parents, who acted as surrogate therapists, pinpointed problem behaviors in themselves or in the child that needed work. Not only were the parents receptive, but the results in correcting socially maladaptive patterns in the children were dramatic. The authors present three case reports to illustrate their success.

TREATMENT PROGRAMS FOR HYPERKINESIS currently most commonly place major emphasis on the well-established effectiveness of amphetamines and methylphenidate. The dramatic improvements so often observed when these agents are introduced can cause other significant and longer-lasting problems to be overlooked. More specifically, although temporary relief is obtained because of decreased motor activity, chronic maladaptive patterns of behavior and interaction can develop between child and parent, child and teacher, and child and peers and may go uncorrected despite medication-induced improvements. Eventually the tensions created by these uncorrected maladaptive patterns manifest themselves and

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are both with the Psychiatric Center at Alvarado, 6310 Alvarado Ct., San Diego, Calif. 92120, where Dr. Furman is Director and Ms. Feighner is a Psychiatric Social Worker and Coordinator of the Treatment Program for Hyperkinetic Children. Dr. Furman is also Assistant Clinical Professor of Psychiatry, University of California, San Diego.

act as severe disruptive influences in the child's future development (1, 2).

The purpose of this paper is to describe a treatment approach for such maladaptive behavior patterns that combines the following three established techniques: 1) videotape feedback confrontation, 2) the use of parents as surrogate therapists, and 3) the application of behavior modification principles to the parents (rather than to the child). It examines a technique used in working with the parents of the hyperkinetic child to enhance their capacity to cope effectively with their youngster's affliction. Parental ineptness in coping with their child's behavior problems results in markedly reduced self-esteem in the affected youngster and subsequently increases his tendencies for antisocial behavior, depression, and other maladaptive manifestations. As a result, even after the basic hyperkinetic problem has run its course, the patient is left with maladaptive traits that can seriously impair his overall adjustment. Often the youngster may be ostracized, not only by his peers, but also at home by his siblings and by his frustrated parents.

THE LITERATURE ON TECHNIQUES

To the extent that we use parents to affect the behavior of their child we are enlisting their help as therapists. That such an indirect therapeutic approach is feasible has been described by other workers (3–6). It has been convincingly held that parents can achieve considerable success in this role because their proximity to the child gives them the opportunity to reinforce behaviors with more regularity than any other person in the child's natural environment.

The literature describes the use of videotape feedback as presenting the opportunity to record a segment of typical interaction between parent and child and then immediately to confront the parent with his own pattern of reaction. With such highly relevant and appropriate data available immediately after occurrence, the learning impact is greatly enhanced (7–17). Principles of learning theory have been therapeutically applied to youngsters who had clinical problems and have resulted in satisfactory modifications in pathological behavior (18, 19). The simultaneous use of parents as auxiliary therapists, instant videotape feedback, and behavior modification principles to train the parents to affect their child's behavior represents a relatively unique combination approach compared with those described in the literature. Only Bernal has delineated use of the video playback technique and behavior modification instruction with parents (17, 20). In our study we focused on subjective data (i.e., parental complaints), used adjunctive chemotherapy, and encouraged interaction in the most recently troublesome areas. Bernal's technique is different in that she relied on a much more structured approach. This included spelling out the nature of the on-camera play interaction, planning ahead to cover a specific aspect of behavior therapy with each interaction, and assigning detailed "homework" to the parents. In addition, she used a home observer to make meticulous measurements. Moreover, her patients received no medication nor were they diagnosed as hyperkinetic, although their behavior according to her description (she uses the phrase "brat behaviors") might well fit this categorization.

METHOD

Behaviors reported by the parents as the most troublesome were the symptoms to be followed for signs of improvement. The parents' subjective evaluation of the child's behavior was the primary indicator we used in this study, although in more recent studies we have already begun to apply specific measurable indices of change that would not rely solely upon the parents' judgment.

Fifteen- to 20-minute segments of interaction were videotaped and used immediately thereafter as a basis for discussion with the parents. In each instance one of us began the session by attempting to probe for and elicit some recent and emotionally laden experience that would serve as a basis for involving the parents and child while on camera. Generally, this took only a few minutes of preliminary discussion. By prearrangement the interviewer then excused himself, and the remainder of the session was recorded with the parents and child alone in the room.

The initial presence of the interviewer proved to be very helpful in getting the subjects over their camera shyness. This was particularly true for the parents; as soon as they were involved with their child they seemed to ignore the camera. Invariably, these brief taping sessions provided more than enough material to be used as a basis for instructing the parents on the principles of coping with the child's behavior.

During the playback sessions, the child was sent back to the waiting room or to the playroom and the parents were instructed in privacy, since not having to cope with the child's presence heightened the parents' receptiveness by making the session seem much more like a period of instruction. Observations by the therapists were used to bring out parents' feelings that had not been conscious, and they then were encouraged to more openly express these feelings to their child.

The initial observations were almost always directed toward the absence of positive reinforcement. No parents were able at first to see much good in their child's behavior since they were oriented exclusively toward negative or undesirable behavior. In part, this was fostered by the fact that the entire context of the interview was focused on problem areas, but the parents readily agreed that positive reinforcement was an area they had grossly neglected. They were also instructed, particularly in subsequent sessions, on the use of intermittent positive reinforcement. Negative or aversive measures were discouraged and recommended only for dangerous or destructive behavior. Careful attention was directed toward role definition. The communicational aspect of the child's behavior, as well as parental responses to it, were carefully interpreted to the parents.

CASE REPORTS

The case reports presented here are those of the first three hyperkinetic children referred after the installation of the closed-circuit television. More families are now being treated with this method, but only those who have had reasonable follow-up periods have been included in this report. The families have similar socioeconomic and educational backgrounds. One of the most important features necessary in the parents was a substantial degree of ego strength. By this we mean that a parent should be able to tolerate critical comments and confrontation as he views himself on the television screen. Although not reported in this study because of lack of time for follow-up, some subsequent patients were found to be untreatable by this technique because of a current disabling psychiatric disorder in the parent.

Notwithstanding our conviction that many families and youngsters with various types of behavior disorders will respond to a similar application of this treatment modality, we chose to report on the hyperkinetic syndrome because it is one that has been reasonably well defined in the literature. All of our patients met Stewart and associates' criteria for hyperkinesis (21) and would fall into the generally used category of minimal brain dysfunction. All had had previous adequate trials on medications alone but, despite some improvement, had retained dysfunctional behavior patterns. It should be stressed that we do not use this therapeutic modality alone as a definitive treatment; the use of medications and coordinated efforts with the school were continued throughout the therapy program.

Case 1. Andy, age eight, met the criteria for hyperkinesis. Although he had had adequate trials on methylphenidate and special education classes, he was doing poorly in school and at home. His schoolwork had improved but maladaptive social behavior patterns had remained unchanged. The parents complained that he always had a stomachache, which "prevented him from doing anything they wanted," and that he was sassy, quick-tempered, stubborn, and immature.

Target behaviors in playback sessions were: the lack of parental consistency in what they expected of Andy, responsiveness to Andy's whining, and frequent misrepresentations of their true feelings, especially anger. Within three sessions, which took place over a six-week period, most of the complaints were gone. A five-month follow-up revealed that communication was better than ever before, that Andy was being reinforced for positive behaviors, that he was doing better socially in school and seemed happier. There has been no recurrence of abdominal pains in four and a half months.

Case 2. Larry, age 13, had been treated with methylphenidate by his family doctor for about one and one-half years when he was referred to this center. His history of hyperkinesis was typical, with the additional factor of a severe educational lag (which many of these youngsters show). He was gradually catching up in school and his hyperactivity had improved, but the tensions in the family, due to years of poor communication, persisted.

Larry was described as stubborn, refusing to talk to his parents, lying, having temper flare-ups, and isolating himself from the family or doing bad things just to get attention. Although the parents were intelligent and reasonable people, their approach to Larry was inconsistent and they often repeated, "We've tried everything and nothing works."

The first session revealed the father as excessively critical and offering no positive reinforcement for good behavior, which he took for granted. The father noted this trait himself and reduced his harshness considerably. A schedule of rules to be strictly enforced was worked out that permitted many of the minor misbehaviors to be ignored. Because of the parents' lifelong tendency to respond only to negative behavior, they were asked to keep a written diary of Larry's positive behaviors, thus heightening their awareness. Subsequent interviews showed a gradual reversal of parental response patterns and the placement of emphasis on the child's assets rather than on his faults. A four-month follow-up showed that both the parents and the child were pleased with themselves and each other.

Case 3. Paul, age 11, was referred to the center by the family physician who had treated the boy's hyperkinesis with partial success using methylphenidate. However, Paul's problems in getting along with others in school had continued, and tensions were worse within the home. His parents were polarized on how to treat him, the father getting stricter as the mother became more lenient. They knew this was a poor approach and openly expressed feelings of guilt but were frustrated because they couldn't seem to do much about it.

Initial contact revealed that Paul was withdrawn and sullen and had begun fighting, stealing, swearing, lying, and frequently leaving home without permission. In the initial replay the father quickly recognized his gruffness, overbearing manner, and the fact that he was overwhelming the boy into sullen silence. The initial target behavior selected was getting Paul to talk. Thereafter, other features were dealt with as they emerged from the more verbal youngster.

After three sessions of feedback, the parents reported very few of the former misbehaviors and that they were, for the first time, enjoying their relationship with Paul. Improvement has been sustained after three months.

DISCUSSION

One of the major advantages of applying this type of therapeutic approach is the availability of an existing relationship between parents and child. It is close, continual, and intimate. The parents' extended exposure to the child gives them the potentiality for having a sustained influence. Even though it contains pathological features, the fact that the close relationship already exists and does not need to be created speeds the course of therapy. This contrasts with the problem of the outside therapist, who must build his own relationship before he can effect therapy.

One might not only consider the parents' ego capacity to modify and to adapt themselves, but also remember that by the time the parents have decided to enter this program they are so fed up with the youngster and his behavior that their motivation to see change is at an unusually high level. The fact that this technique offers change in a remarkably short period of time further commends it. The use of traditional psychotherapeutic approaches in this situation could easily result in losing many cases because they did not see change happening fast enough. The

parents were unusually receptive to the instructions given in the playback session, and it was interesting to note how little conscious effort was involved in their maintaining at home a consistently changed approach to their children.

The videotape feedback aspect of the treatment program is directed exclusively at the parent (even though the child is the patient), since many parents cannot accept therapeutic intervention if they themselves must be the identified patient. On the other hand, they can take a certain degree of pride in being therapists themselves. They seem to enjoy being taught how to treat their child, as opposed to turning the treatment over to somebody else, as with traditional therapy. Consequently, much of the guilt and resistance we expected to encounter did not appear.

We discovered that one of the most effective means of applying learning principles during the 15- to 20-minute segment of parent-child interaction was to select a piece of "target behavior." As the two therapists sat in the monitoring room, they were able to discuss the interaction without interfering and at the same time to isolate significant patterns of interaction. Nonverbal or paralinguistic phenomena, such as diverting the subject of discussion and using baby talk and eye contact, were typical target behaviors. We felt it was most important to be able to isolate on camera a specific behavior that the parent could identify, unmistakably recognize, and want to change. It was our expectation that if the parent could learn to modify this one target behavior, he could then generalize the same principles to other behaviors that bothered him; this indeed proved to be the case.

Furthermore, because we did not throw too many specific instructions and criticisms at the parent, he was better able to master the one modification successfully. Then, building on his initial success, he tackled the next behavior with much greater confidence. For example, in Paul's case, the target behavior was verbalization. The father found that his son's refusal to speak was exceedingly frustrating, and to this he reacted with anger, which only further intimidated his son. As a result, a vicious circle was established. But when verbalization was set up as the target behavior (and immunity from punishment for telling lies was temporarily granted), Paul felt freer to verbalize. The father then proceeded to apply the lessons he was given—and with striking success. Once he found out what was going on in his son's mind he had little difficulty coping with the newly discovered information. He later reported that this recognition had also helped him at work, for he saw himself behaving similarly with co-workers and subordinates. As a result, his relationships with them also improved.

In adding the videotape feedback technique to the overall treatment program we feel that we treated in an effective and short-term fashion the overlooked component that is usually present in the hyperkinetic youngster, namely, the maladaptive pattern in his interpersonal relationships. Parents commented, for example, on the lessening tension in the family. The youngsters themselves recognized that things were "better at home," even though they could not be more specific about what kind of changes had occurred. Most importantly, the parents were delighted with the very dramatic changes that occurred, and for the first time they saw their children as individuals with positive qualities.

SUMMARY

We have reported some striking results obtained in treating hyperkinetic children by adding to the usual program several sessions with videotape feedback in which short segments of interaction between parent and child were videotaped and followed by an instant replay session with parents and therapists alone. On-camera target behaviors were isolated, and parents were then instructed in detail in the application of behavior modification principles to their child's conduct. Positive reinforcement was emphasized but consistently proved to be the most difficult to effectuate. Parents were instructed in the judicious use of mild verbal aversive stimulation and extinction. Results in the first three consecutive referrals in which the technique was applied were sufficiently dramatic to warrant the preparation of this paper.

Parents were very receptive. Target behaviors responded readily, and in all three cases significant generalization of the effect was reported in off-camera behavior patterns of both parents and child. Prior to the use of this technique all patients had been adequately medicated but, despite reduction in hyperkinesis, still showed severe socially maladaptive patterns. Although follow-up thus far has not exceeded six months, improvement has been maintained at almost asymptomatic levels in all three patients.

Of great significance is the apparent efficaciousness of a treatment modality that uses the parents as surrogate therapists in a program that can alter troublesome behavior in parent and child alike. The technique has been included as part of an overall program employing chemotherapy, group counseling for parents, and cooperative efforts with teachers. Future studies of this technique will include objective criteria of measurement and longer follow-up periods.

REFERENCES

1. Werry JS: Developmental hyperactivity. Pediatr Clin North Am 15:581–599, 1968
2. Stewart MA: Hyperactive children. Sci Am 222:94–98, 1970
3. Hawkins RP, Peterson RF, Scheid E, et al: Behavior therapy in the home. J Exp Child Psychol 4:99–107, 1966
4. Lindsley OE: An experiment with parents handling behavior at home. Johnstone Bulletin 9:27–36, 1966
5. Wahler RT, Winkel GH, Peterson RF, et al: Mothers as behavior therapists for their own children. Behav Res Ther 3:113–124, 1965
6. Becker WC: Teaching Children. Champaign, Ill, Engleman-Becker Corp, 1969
7. Boyd HS, Sisney VV: Immediate self-image confrontation and changes in self-concept. J Consult Psychol 31:291–294, 1967
8. Danet BN: Videotape playback as a therapeutic device in group psychotherapy. Int J Group Psychother 14:433–440, 1969
9. Moore FJ, Schernell E, West MJ: Television as a therapeutic tool. Arch Gen Psychiatry 12:217–220, 1965
10. Resnikoff A, Kagan N, Schauble PG: Acceleration of psychother-

apy through stimulated videotape recall. Am J Psychother 24:102–111, 1970
11. Bailey KG: Audiotape self-confrontation in group psychotherapy. Psychol Rep 27:439–444, 1970
12. Bailey KG, Sowder WT Jr: Audiotape and videotape consultation in psychotherapy. Psychol Bull 74:127–137, 1970
13. Berger MM: Videotape Techniques in Psychiatric Training and Treatment. New York, Brunner/Mazel, 1970
14. Danet BN: Self-confrontation in psychotherapy reviewed. Am J Psychother 22:245–257, 1968
15. Geertsma RH, Reivich RS: Repetitive self-observation by videotape playback. J Nerv Ment Dis 141:29–41, 1965
16. Holzman PS: On hearing and seeing oneself. J Nerv Ment Dis 148:198–209, 1969
17. Bernal M: Behavioral feedback and the modification of brat behaviors. J Nerv Ment Dis 148:375–385, 1969
18. Weiss G: Treatment of hyperactivity in children. Curr Psychiatr Ther 10:26–29, 1970
19. Wolf R, Risley T, Mees T: Application of operant conditioning procedures to the behavior problems of the autistic child. Behav Res Ther 1:305–312, 1964
20. Bernal M: Training parents in child management, in Behavior Modification in the Learning Disorders. Edited by Bradfield R. San Rafael, Calif, Academy Therapy Publications, 1971, pp 41–67
21. Stewart MA, Pitts FN, Craig AG, et al: The hyperkinetic child syndrome. Am J Orthopsychiatry 36:861–867, 1966

Caffeine as a Substitute for Schedule II Stimulants in Hyperkinetic Children

BY ROBERT C. SCHNACKENBERG, M.D.

Children being treated with methylphenidate or dextroamphetamine for minimal brain dysfunction syndrome and subsequent hyperkinetic impulse disorder may develop annoying side effects. A pilot study substituting caffeine, in the form of two cups of regular coffee a day, suggests that caffeine may be a suitable alternative to Schedule II drugs. The author points out the advantages of treatment with caffeine and suggests some specific aspects for further studies in this area.

METHYLPHENIDATE HYDROCHLORIDE and dextroamphetamine sulfate are medications widely used (1, 2) in treating children with minimal brain dysfunction syndrome and subsequent hyperkinetic impulse disorder. While taking histories from hyperkinetic children and their parents, I have noted that an unusually high percentage of these children drink coffee. When these children were asked why they drank coffee, they replied, "It calms me down," or, "I can do better in school."

Some children with minimal brain dysfunction and subsequent hyperkinesis who are receiving methylphenidate or dextroamphetamine have been noted to develop annoying side effects, despite improvement in attention-concentration-motility-impulse dyscontrol (3). These side effects include insomnia, anorexia, weight loss, nervousness, and abdominal pain. Parents frequently balk at giving their children Schedule II medications because of their side effects. It was therefore decided to administer small amounts of a very widely used stimulant, caffeine (in coffee), to these children to see whether annoying side effects could be eliminated while maintaining relief from symptoms.

Dr. Schnackenberg is Chief, Child and Adolescent Service, William S. Hall Psychiatric Institute, Box 119, Columbia, S.C. 29202.

METHOD

Eleven consecutive children whose hyperkinetic symptoms had improved on methylphenidate (the only drug I currently prescribe for this disorder) but who developed annoying side effects were transferred to caffeine, in the form of one cup of coffee at breakfast and one at lunch. The rationale was carefully explained to the parents: the caffeine content of a cup of regular percolated, drip, or vacuum coffee is 100–150 mg. (4) and we hoped to eliminate the annoying side effects of the medication while maintaining the therapeutic benefits. (Incidentally, instant coffee has 86–95 mg. of caffeine per cup and decaffeinated coffee has 2–4 mg. per cup [4].)

At this time, all methylphenidate was stopped and each child was given a medication holiday for three weeks. Then each child was to drink a cup of regular coffee at breakfast and another one at lunch. Schoolteachers were intentionally not told about these changes, so that they could respond as objectively as possible about any possible changes in the child's behavior, first during the period off all medications and then while drinking coffee. Teachers and parents were each questioned at weekly intervals for six weeks: during the three weeks off all medication and during the first three weeks on coffee (caffeine).

TABLE 1
Patients' Side Effects on Methylphenidate and Scores on Rating Scales for Hyperkinesis

Patient	Age at Which Methylphenidate Started (Years–Months)	Age at Which Methylphenidate Discontinued (Years–Months)	Side Effects Attributed to Methylphenidate*	Scores on Rating Scales for Hyperkinesis		
				Methyl-phenidate	No Drugs	Caffeine
1	8–4	8–5	Insomnia	18	26	19
2	7–6	8–6	Anorexia, no weight gain	16	27	16
3	8–0	8–9	Anorexia, weight loss	19	26	18
4	7–3	7–5	Insomnia	19	26	17
5	7–10	8–4	Anorexia	16	25	16
6	7–6	8–1	Anorexia	14	24	15
7	6–7	7–0	Anorexia, weight loss	19	26	17
8	8–5	8–8	Anorexia, weight loss	18	26	17
9	8–3	8–9	Insomnia	13	24	15
10	7–9	8–4	Anorexia, no weight gain	19	29	18
11	7–4	8–3	Anorexia	18	26	17

*All side effects listed disappeared during treatment with coffee.

The Rating Scale for Hyperkinesis by Davids (5) was administered to the teachers on three different occasions: during the child's last month on methylphenidate, during the child's last week off all medication, and during the child's third week on coffee.

RESULTS

According to Davids, a score of 24 or more on his Rating Scale for Hyperkinesis suggests the presence of hyperkinesis in the child. Scores ranging from 19 to 23 are regarded as suspicious, and scores of 18 or less are viewed as indicating the absence of significant hyperkinesis in the child. The mean score of children on methylphenidate, as judged by their teachers, was 17.2, the mean score while receiving no drugs was 25.9, and the mean score on coffee (caffeine) was 16.8 (see table 1). While the mean scores on methylphenidate and caffeine were roughly the same, the mean score while off all drugs was clearly in the hyperkinetic range. The annoying side effects disappeared and no side effects appeared that could be traced to the coffee (caffeine).

I have noted no difference between the course of these 11 children on coffee and that of approximately 300 children I have treated with methylphenidate hydrochloride or dextroamphetamine sulfate, except for the lack of annoying side effects. These 11 children have been maintained on coffee, following an initial trial period, for an average of 6.2 months. Three of the oldest children (average age = 9.6 years) appear to have outgrown the need for psychostimulants and their paradoxical effects after being on caffeine for an average of 8.3 months.

The children in this study received from 200 to 300 mg. of caffeine per day. Attempts at doubling (400–600 mg. of caffeine per day) and halving (100–150 mg. per day) the dosage were made. In this small sample, no improvement over the 200–300 mg. per day dosage was noted, which suggests that the 200–300 mg. range may be optimal for many children.

CASE REPORT

Donnie (patient 2) was referred for evaluation in December 1970 at age seven and a half. His parents related that he was repeating the first grade because he couldn't attend to his classroom teacher and had problems with hyperactivity and impulse control.

Mental status examination revealed an engaging but very hyperactive child. Neurological examination revealed mixed and confused laterality, along with some fine motor incoordination. An electroencephalogram showed mild diffuse bilateral dysrhythmia. Psychological testing showed many "neurological indicators" on the Bender-Gestalt test, with a full scale IQ on the Wechsler Intelligence Scale for Children of 105.

A diagnosis of minimal brain dysfunction syndrome with subsequent hyperkinetic impulse disorder was made and Donnie was begun on 10 mg. of methylphenidate hydrochloride at breakfast and lunch. Marked improvement was evidenced in his attention-concentration-motility-impulse dyscontrol-problems.

In December 1971, it was noted that Donnie had failed to gain weight during his year on methylphenidate. This was felt to be due to the slight anorexia that it had caused. Methylphenidate was stopped, and Donnie was given a three-week holiday off all medications. He was then begun on a cup of regular coffee at breakfast and lunch. Upon questioning, his teacher reported a return of his symptoms during his three weeks off methylphenidate, while he was "back to his old self" after being placed on coffee (caffeine). His parents reported similar findings and were pleased with his performance on coffee. Donnie's performance on coffee appears to be the same as on methylphenidate: no better and no worse. However, his anorexia has disappeared, and he has gained two pounds over the last six months.

DISCUSSION

Methylphenidate hydrochloride and dextroampheta-

mine sulfate were placed on Schedule II by the Bureau of Narcotics and Dangerous Drugs in January 1972. Both of these drugs have been subjected to abuse by adolescents and adults, but a long-term follow-up study by Laufer (6) indicated that children with "minimal cerebral syndromes" were not significant drug-abuse risks in later life. Sensationalized reports regarding misuse of medication among Nebraska schoolchildren and by a syndicated columnist referring to physicians as "speed merchants and dope pushers" have cast some doubts among the public in regard to using psychostimulants for hyperkinetic children. In a conference on January 11–12, 1971, sponsored by the Office of Child Development and the Office for Health and Scientific Affairs, a panel of 15 specialists in various disciplines sanctioned the use of stimulant medications under appropriate medical supervision (7).

Nevertheless, it is felt that alternatives to the abused and controversial Schedule II stimulants, such as methylphenidate hydrochloride and dextroamphetamine sulfate, should be available. In addition, the cost per child on Schedule II stimulants is approximately $100 per year, while the cost of coffee is approximately $10 per year per child. This is no small matter, since some hyperkinetic children receive central nervous system stimulants for several years. In addition, coffee (caffeine) apparently produces fewer annoying side effects in these particular children.

This pilot study suggests that caffeine may have a place in the therapeutic management of the child with minimal brain dysfunction syndrome and subsequent hyperkinetic impulse disorder. A more definitive study utilizing citrated caffeine tablets has been planned. As with all medications administered to children, the therapeutic benefits must be carefully weighed against any possible harm.

It is suggested that rigorous studies be carried out comparing the effectiveness of caffeine with that of methylphenidate hydrochloride, dextroamphetamine sulfate, magnesium pemoline, and placebo for both patient and control groups. A double-blind crossover methodology (8) could be devised. Great care should be taken in making the proper diagnosis. Perhaps studies using Conners' method of cluster analysis of subgroups of hyperkinetic children (3) could be utilized. His attempt to match *specific* hyperkinetic subgroups with *specific* therapeutic regimens seems promising. For example, some children may respond best to caffeine and others to methylphenidate hydrochloride.

I have noted that minimal brain dysfunction syndrome with subsequent hyperkinetic impulse disorder seems to be most heavily reported in countries where children are predominantly milk-drinkers and not coffee-drinkers, i.e., the United States, Canada, and the British Isles (the tea drunk by British youngsters has a low, and probably therapeutically ineffective, caffeine content). I have been unable to find definitive reports of minimal brain dysfunction syndrome and subsequent hyperkinetic impulse disorder in South American countries, where young children drink coffee several times a day, beginning at an early age. The syndrome surely exists, but apparently without enough intensity to be reported.

Therefore, the sociology of minimal brain dysfunction syndrome and subsequent hyperkinetic impulse disorder needs investigation. Are the children in countries where early coffee drinking is widely accepted *inadvertently treating their own symptoms* of attention-concentration-motility-impulse dyscontrol by drinking coffee? This seems to be the case for several children that I have seen. Is there an inverse relationship between the symptoms of such dyscontrol and the prevalence of coffee drinking among young children?

REFERENCES

1. Eisenberg L: The management of the hyperkinetic child. Dev Med Child Neurol 8:593–598, 1966
2. Millichap JG, Fowler GW: Treatment of "minimal brain dysfunction" syndromes. Pediatr Clin North Am 14:767–777, 1967
3. Conners CK: Recent drug studies with hyperkinetic children. Journal of Learning Disabilities 4:476–483, 1971
4. Dipalma J: Drill's Pharmacology in Medicine. New York, McGraw-Hill, 1971, p 547
5. Davids A: An objective instrument for assessing hyperkinesis in children. Journal of Learning Disabilities 4:499–501, 1971
6. Laufer MW: Long-term management and some follow-up findings on the use of drugs with minimal cerebral syndromes. Journal of Learning Disabilities 4:519–522, 1971
7. Report of the Conference on the Use of Stimulant Drugs in the Treatment of Behaviorally Disturbed Young School Children. Washington, DC, Department of Health, Education, and Welfare, 1971
8. Schnackenberg RC, Bender EP: The effect of methylphenidate hydrochloride on children with minimal brain dysfunction syndrome and subsequent hyperkinetic syndrome. Psychiatric Forum 2(2):32–36, 1971

EDITORIAL

The Current Status of Child Psychiatry

CHILD PSYCHIATRY AS A MEDICAL SUBSPECIALTY today enjoys more status than it has ever had before, but not nearly enough to fulfill its obligations. While it has had official recognition as a subspecialty for something more than ten years and has accredited training programs as well as trainees, it still faces many challenges. While some of these are being met and partially conquered, others still await action.

Some of the most important features about child psychiatry today are the following:

- Far too few child psychiatrists are being trained to meet the rising demand for their services.
- Many trainees in this field are given experiences that do not prepare them to comfortably accept the challenges in their future professional careers.
- Research training in child psychiatry is at best minimal and spotty.
- Community mental health has provided a great deal more time and money for adult patients than for youth.
- The "advocacy" system proposed by the Joint Commission on Mental Health of Children has merit but also many hazards. The problems of money as well as of methods are as yet to be solved.
- Child psychiatry is a field that from an emotional standpoint seems attractive to many young people entering medicine. However, they must first face the years of medical school. It would appear that there are far more freshman medical students oriented toward a career in adult or child psychiatry than eventually enter such training. What is even more difficult to understand is that those who enter medical school with aspirations to become adult or child psychiatrists do not necessarily form the bulk of those who eventually do so.

There are perhaps three reasonable answers to this dilemma. One is that medical schools in general do not give child psychiatry a sufficient amount of time in the curriculum. The next is that many specialists in other fields tend to discourage the potential child psychiatrist from entering this area and encourage him instead into their own. Finally, and perhaps most importantly, it may be that we do not have enough good teachers in child psychiatry. One need only ask medical students about their experiences in child psychiatry to find that not only have they often had very little exposure but that what they did have was unimpressive to them.

- Finally, there is the concept that was prominent when the first child guidance clinics were founded that psychiatric treatment of children would be particularly rewarding since the patients are young and therefore presumably easier to help. Unfor-

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they be construed as marking the official policy of the Journal.

tunately, this did not take sufficiently into account the problems encountered in treating parents of the children. Earlier medical experiences of most parents have led them to believe that the doctor will cure their child—by surgery, antibiotics, or some other rapid means—and return him to them in a healthy condition. Bringing their child for help with emotional problems is not quite so simple. For example, the concept that they themselves will be involved in the treatment and may need to examine their own personalities as well as their own marriage is not only more than they had bargained for, but quite time-consuming in addition.

One important aspect, which is only gradually becoming accepted, is that of primary prevention in the form of family planning. There are literally hundreds of thousands of unplanned, unwanted children born each year, but child psychiatrists usually leave advice about family planning to obstetricians and gynecologists.

There have been a number of important developments in child psychiatry during recent years; reviewing them gives cause for optimism.

1. An increased study and knowledge of constitutional differences in infants and how constitutional factors interact either well or poorly with parental expectations.
2. A movement toward very early intervention (e.g., Head Start), but the growing awareness that such programs may be too little, too late; unless such a program is continued, it is not permanent in its effects.
3. The growing, but as yet limited, participation with other specialists (i.e., pediatricians, neurologists, educators, and others) in studies of psychosomatic ailments, neurological problems, and learning difficulties, etc.
4. The gradual but far from complete increase in our understanding of early infantile autism, symbiotic psychosis of childhood, and borderline states.
5. A better understanding of the etiology, early recognition, treatment, and even prevention of various forms of mental retardation.

STUART M. FINCH, M.D.

Dr. Finch is Professor of Psychiatry at the University of Michigan Medical School, Ann Arbor.

Fluphenazine Enanthate and Fluphenazine Decanoate: A Comparison of Their Duration of Action and Motor Side Effects

BY H.M. VAN PRAAG, M.D., PH.D., AND L.C.W. DOLS

Fluphenazine enanthate and fluphenazine decanoate—two long-acting neuroleptics—were administered in a controlled comparative study to 30 patients with acute psychoses of different character and origin. The study compared the duration of action and affinity for the extrapyramidal system of the two drugs. The decanoate ester acted longer than the enanthate ester and provoked fewer motor side effects. Since these side effects greatly reduce the patient's motivation to cooperate in taking depot medication, the decanoate ester is to be preferred.

FLUPHENAZINE ENANTHATE and fluphenazine decanoate are long-acting neuroleptic drugs. Administration of neuroleptics of this type has proved to be advantageous (1) because, in patients with chronic recurrent psychoses, they reduce the risk of carelessness with maintenance doses (2) and therefore the risk of relapse (3). The merits and demerits of the administration of long-acting neuroleptics in the treatment of acute and chronic psychoses have been discussed in earlier publications (4, 5).

The effect of a single intramuscular injection of fluphenazine enanthate lasts about two weeks. Motor side effects are frequently observed, particularly during the first few days after injection (4, 6, 7). This is a serious disadvantage because it may give the patient reason to resist this form of therapy, and such resistance would undermine the rationale of long-acting medication.

Fluphenazine decanoate is believed to have a more protracted effect than the enanthate ester (about four weeks) and to produce fewer motor side effects (8–10). This allegation, however, is not based on controlled comparative studies of the two agents in human subjects. Two such studies that were done on chronic hospitalized psychiatric patients failed to reveal any distinct difference between the two agents (11, 12). In both cases, however, the experimental setup was not quite suitable for demonstrating the possible differences in duration of action and extrapyramidal affinity. The experiment described in this article was specifically set up to compare the two fluphenazine esters in the aforementioned respects. It was done with acutely psychotic patients.

The authors are with the Department of Biological Psychiatry, Psychiatric University Clinic, 59 Oostersingel, Groningen, the Netherlands, where Dr. van Praag is Professor of Biological Psychiatry and Ms. Dols is Research Assistant.

METHOD

The group examined consisted of 30 patients who were hospitalized on the research ward of the Department of Biological Psychiatry, Psychiatric University Clinic, Groningen, because of psychotic symptoms of varying etiologies and modes of manifestation (see table 1). If at all possible, treatment was not started until after the beginning of the second week of hospitalization. This was done in order to eliminate all patients whose reintegration was ensured by the mere fact of hospitalization. Twenty-two patients began treatment in the second week and eight, because of serious agitation or anxiety, in the first week. When treatment was started, the physician as well as the nurse regarded all patients as psychotic and in need of neuroleptic medication.

The average age of the patients in the enanthate group was 44 years, with a range of 21 to 70. In the decanoate group the average age was 40 years, with a range of 19 to 65. The enanthate group included eight women and six men, and the decanoate group consisted of 11 women and five men.

The test subjects were randomly divided into two groups. One group received 25 mg. of fluphenazine enanthate intramuscularly at the start of the investigation period, while the other group received 25 mg. of fluphenazine decanoate intramuscularly. The conditions of a double-blind test were ensured.

TABLE 1
Predominant Syndromal and Etiological Characteristics of the Patients Treated (N=30)

Etiology	Paranoid with Ideas of Reference		Delusions (Excluding the Paranoid)		Hallucinations		Motility Disorders	
	Enanthate	Decanoate	Enanthate	Decanoate	Enanthate	Decanoate	Enanthate	Decanoate
Schizophrenic "process"	4	2	1	2	1	1		
Demonstrable cerebral process						1		
Demonstrable extracerebral process		1		1	1			1
Psychogenic (including sociogenic and neurotic) factors	3	3	3	2	1	1		1

During the four weeks following the injection, all patients of both groups were given one capsule three times daily. In principle, these capsules contained an inert substance; however, they could be replaced by identical capsules filled with 50, 100, or 150 mg. of chlorpromazine (Largactil).

Apart from the incidental administration of a barbiturate-type hypnotic, no other medication was prescribed.

Whether a patient required chlorpromazine instead of placebo on a given day, and how much, was always determined by the same psychiatrist on the basis of the patient's clinical condition. The psychiatrist aimed at giving the minimal effective dosage. He was not involved in scoring and did not know which patients were in the enanthate group and which in the decanoate group. Every day the senior nurse on the research ward received the capsules from a research assistant, who indicated which patients were to receive which capsules. The evaluators—physicians and nurses—were blind to the distribution of enanthate and decanoate as well as to the contents of the capsules given.

The following hypothesis was tested: If fluphenazine decanoate acts longer than fluphenazine enanthate, then during the latter half of the period of investigation the number of patients requiring supplementary medication and the amount of supplementary medication given per patient should be smaller in the decanoate group than in the enanthate group.

Two rating scales were used. Scale A, a modified Wing scale (13), is a three-point rating scale aimed at visible variables of behavior. Scoring on this scale was done by the senior nurse of the ward. Scale B is a three-point rating scale, the scoring of which requires verbal communication with the patient. Scoring on this scale was done by the attending physician and a physician not involved in the treatment, both of whom worked independently. Scoring on both scales was done prior to the administration of medication and twice weekly during the treatment period, and was always done on the same days of the week at the same time of day.

At the end of the fourth week of treatment each of the three evaluators made a final scoring that signified the patient's improvement or nonimprovement over his pretherapeutic condition. The scoring was done on a five-point scale that ranged from marked improvement to no improvement to deterioration.

The psychiatrist prescribing the daily capsules also evaluated the patient's motor status. As soon as hypertonic, hypokinetic, or dyskinetic symptoms occurred, he prescribed orphenadrine (Disipal) in daily doses ranging from 75 to 300 mg. He continued to strive to prescribe the minimal effective dosage.

The hypothesis tested here was that if fluphenazine decanoate is less provocative of motor symptoms than fluphenazine enanthate, then—particularly during the first week following the injection—the number of patients requiring orphenadrine and the amount of orphenadrine per patient should be smaller in the decanoate group than in the enanthate group.

Blood, liver functions (serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and alkaline phosphatase), and urine (protein, urobilin, and sediment) were also examined once weekly.

TABLE 2
Results of One-Tailed Test for an Increasing or Decreasing Trend in the Summated Scores Before and During Treatment

Evaluator	Summated Scores per Patient		Summated Scores per Item	
	T Score	Significance	T Score	Significance
Nurse				
Enanthate	6.40	$p<.01$	5.34	$p<.01$
Decanoate	5.56	$p<.01$	4.98	$p<.01$
Physician 1*				
Enanthate	6.37	$p<.01$	5.15	$p<.01$
Decanoate	7.28	$p<.01$	6.36	$p<.01$
Physician 2**				
Enanthate	4.95	$p<.01$	5.73	$p<.01$
Decanoate	5.84	$p<.01$	6.94	$p<.01$

*Attending physician.
**Physician not involved in treatment.

RESULTS

The degree of agreement between the scores of the two physicians, calculated from the pretherapeutic scores, ranged from r = .56 for the item "contact" to r = .76 for the item "mood" (Bravais-Pearson correlation coefficient). All correlation coefficients differed significantly from zero ($p < .01$) but were in our opinion too low to justify combining the two scores. The scores of the two physicians will therefore be separately analyzed. A previous study (4) had revealed a high interrater reliability (r = .85) on scale A. For this reason, it was entrusted to a single nurse in this study.

The scores on scales A and B were analyzed in two different ways. We calculated: 1) the total scores on all items for each patient and 2) the scores for each item, which were summated for all patients. Applying the test to point up an increasing or a decreasing trend in m rankings (one-tailed test) showed that in the course of the four weeks of treatment both groups showed significant improvement (see table 2). In addition, according to the final scores, all evaluators regarded the clinical condition of both groups as improved at the end of the treatment period.

Measured by the difference between the last and the first summated scores for each patient and for each item, neither the nurse nor the physicians found a difference in the degree of improvement between the enanthate group and the decanoate group (Mann-Whitney U test and Wilcoxon test). According to the final scores, the mean improvement in both groups was between slight and marked.

Comparison of the pretherapeutic scores in the enanthate group and in the decanoate group revealed no significant difference. The therapeutic results, therefore, were not demonstrably influenced by a difference in severity of symptoms between the two groups.

A hypnotic had been administered to ten patients from the enanthate group and to 13 from the decanoate group for more than 14 nights of the investigation period. There was no significant difference between the groups regarding the amount of barbiturate given per night per patient.

During the third week of medication, eight of the 14 patients in the enanthate group and three of the 16 in the decanoate group needed chlorpromazine. The difference lies at the limit of the $p = .05$ level of significance (Fisher test). During the fourth week of medication the corresponding numbers were ten and four patients, respectively (see table 3). This difference is statistically significant at the $p < .05$ level (Fisher test).

During the first two weeks of the period of investigation, the enanthate and decanoate groups did not significantly differ in the number of patients requiring supplementary chlorpromazine medication (see table 3).

In the group of ten enanthate patients who needed supplementary chlorpromazine, the total per patient during the last two weeks of the study period averaged 4700 mg. Two patients received a total amount of less than 3000 mg. during this period.

The four decanoate patients who needed chlorpromazine during the last two weeks of the study period each received an average of 2500 mg.; none received more than 3000 mg. during this period.

TABLE 3
Number of Patients Who Required Chlorpromazine or Orphenadrine

Category	Enanthate Group (N = 14)	Decanoate Group (N = 16)
Chlorpromazine		
Week 1	2	1
Week 2	4	3
Week 3	8	3
Week 4	10	4
Orphenadrine		
Week 1	11	3
Week 2	8	4
Week 3	3	2
Week 4	3	3

The number of patients for whom a small dose of chlorpromazine was sufficient (less than 3000 mg. in two weeks) was significantly greater in the decanoate group than in the enanthate group ($p < .05$, Fisher test).

During the first week studied, orphenadrine was prescribed for 11 of the 14 enanthate patients and for three of the 16 decanoate patients (see table 3). The number of patients in need of orphenadrine was significantly smaller in the decanoate than in the enanthate group ($p<.05$, Fisher test).

The 11 enanthate patients who needed orphenadrine during the first week received an average of 1700 mg. per patient. Three of them received less than 1200 mg. during this period. The three decanoate patients who received orphenadrine during this period averaged a total of 1100 mg. per patient. None received more than 1200 mg. The difference between the two groups in this respect, however, was not statistically significant.

Three patients (two in the enanthate group, and one in the decanoate group) were excluded during the first week of the study. This means that 33 patients were studied in order to form a group of 30 subjects. Exclusion of patients was not dictated by side effects but always by a fulminating course of the psychosis, which demanded more drastic measures (parenteral administration of neuroleptics or ECT). Apart from the motor symptoms, no significant side effects were observed. The blood picture and renal and liver functions showed no systematic changes.

DISCUSSION

The enanthate and the decanoate groups showed the same degree of improvement according to all raters and all rating methods used. In view of the additional administration of chlorpromazine, no judgment can be made on the relative therapeutic value of both preparations.

In order to settle the question of whether the decanoate

ester of fluphenazine acts longer than its enanthate ester, the following test arrangement was chosen. The two drugs were administered once in two comparable groups of patients with acute psychoses. Efforts were made to keep the patients in optimal condition during the next four weeks, if necessary by controlled supplementary chlorpromazine medication. We tested the hypothesis that the need for supplementary medication should be manifested earlier and/or be more evident in the enanthate than in the decanoate group.

During the first two weeks studied, the two groups did not significantly differ in the number of patients who needed supplementary chlorpromazine medication. During the latter half of the period studied, fewer decanoate than enanthate patients required chlorpromazine and the amount of chlorpromazine prescribed for each patient was smaller in the decanoate than in the enanthate group. These findings warrant the conclusion that the effect of the decanoate ester lasts longer than that of the enanthate ester.

The possible difference in extrapyramidal affinity between the two compounds was assessed on the basis of the amount of orphenadrine required to keep the motor status within normal limits. The number of patients who needed orphenadrine during the first week after injection was larger in the enanthate group than in the decanoate group. Moreover, the individual orphenadrine requirements of the former group exceeded those of the latter. This last difference, however, was not statistically significant.

The higher requirement for orphenadrine in the enanthate group did not result from their use of more chlorpromazine, since the increased use of chlorpromazine occurred during the latter half of the period studied, while the increased orphenadrine requirement occurred within the first week. These findings warrant the conclusion that the decanoate ester is less provocative of untoward motor effects than the enanthate ester.

REFERENCES

1. Lowther J: The effect of fluphenazine enanthate in chronic and relapsing schizophrenia. Br J Psychiatry 15:691–692, 1969
2. Renton CA, Affleck JW, Carstairs GM, et al: A follow-up of schizophrenic patients in Edinburgh. Acta Psychiatr Scand 39:548–581, 1963
3. Prien RF, Cole JO, Belkin NF: Relapse in chronic schizophrenics following abrupt withdrawal of tranquillizing medication. Br J Psychiatry 115:679–686, 1969
4. Van Praag HM, Breetveld J, Van Mesdag-Etty H, et al: A controlled comparative study of fluphenazine and fluphenazine enanthate in acute and chronic psychotic patients. Psychiatr Neurol Neurochir 73:165–175, 1970
5. Van Praag HM, Schut T, Dols L, et al: Controlled trial of penfluridol in acute psychosis. Br Med J 4:710–713, 1971
6. Millar J, Daniel GR: A trial of fluphenazine enanthate in chronic schizophrenia. Br J Psychiatry 113:1431–1432, 1967
7. Malm U: Intramuscular long-acting fluphenazine in the treatment of schizophrenia. Acta Psychiatr Scand 46:226–237, 1970
8. Neal CD, Imlah NW: Fluphenazine decanoate: a second long-acting phenothiazine. British Journal of Social Psychiatry 2:178–186, 1968
9. Graefe F: Ein neuer Weg zur Dauerbehandlung chronischer psychosen. Nervenarzt 39:279–281, 1968
10. Ayd FJ Jr: Fluphenazine decanoate—another long-acting injectable phenothiazine neuroleptic. International Drug Therapy Newsletter 5:13–16, 1970
11. Kurland AA, Richardson JH: A comparative study of two long-acting phenothiazine preparations, fluphenazine enanthate and fluphenazine decanoate. Psychopharmacologia 9:320–327, 1966
12. Itil T, Keskiner A: Fluphenazine hydrochloride, enanthate, and decanoate in the management of chronic psychosis. Dis Nerv Syst 31(suppl 9):37–42, 1970
13. Wing JK: A simple and reliable subclassification of chronic schizophrenia. J Ment Sci 107:862–875, 1971

The Paraprofessional Teaches the Professional

BY JOHN A. TALBOTT, M.D., ANITA M. ROSS, PH.D., ALAN F. SKERRETT, MARION D. CURRY, STUART I. MARCUS, M.A., HELEN THEODOROU, M.S.W., AND BARBARA J. SMITH, R.N., M.A.

Most articles written about paraprofessionals have discussed their new and expanded roles, their assumption of tasks not dealt with by professionals, and their training by professional mental health workers. This paper looks at the other side of the coin: the unique contributions paraprofessionals can make to mental health treatment programs and their underutilized skill in training professional mental health workers.

MOST ATTENTION directed toward the training of paraprofessionals,[1] ancillary mental health personnel, mental health aides, technicians, and attendants has emphasized their acquisition of new skills so that they can undertake new tasks in the care of the mentally ill. However, little attention has been given to the contributions of paraprofessionals in the training of professional mental health workers. While we are concerned with the two-way dialogue and learning experiences that take place between paraprofessionals and professionals, this report will concentrate on the role paraprofessionals can play in the *training of* psychiatrists, psychologists, social workers, nurses, occupational therapists, and recreational therapists.

THE NEW YORK CITY-LONG ISLAND REGIONAL TRAINING TEAM

The New York City-Long Island Regional Training Team was established by the New York State Department of Mental Hygiene in 1970 to mobilize and train other interdisciplinary teams in the 22 state hospitals and state schools in the New York City and Long Island area. It consisted, in 1971, of two psychologists, two psychiatric attendants, one psychiatrist, one social worker, one nurse, and an administrator. Its goal is to upgrade the skills, effectiveness, and treatment knowledge of ward attendants in order to improve psychiatric and rehabilitative care for patients in, and population groups served by, these institutions.

In its two-year history the Regional Training Team has been involved in: 1) training existing or newly formed training teams, 2) training clinical administrators, 3) training prototypical training units, 4) training former discipline chiefs to restructure their roles and to act as members of interdisciplinary training teams, and 5) conducting specialized workshops in such areas as team building, group therapy, crisis intervention, and treatment techniques. The material presented here is based on this experience in dealing with clinicians, administrators, and support service personnel from every mental health discipline and from all organizational levels.

THE ATTENDANT'S CONTRIBUTIONS

The attendant occupies an unusual position in the mental hospital inpatient service. Because he has continuous contact with a large number of patients, and is an integral part of the total ward milieu or structure, his observations, decisions, and actions are of primary importance to any therapeutic program.

The attendant is often more available and accessible to patients than are members of other disciplines, and he observes the patient in the day-to-day, 24-hour, practical, and social situations that constitute daily life. He sees variations in the patient's behavior, he observes the patient in one-to-one and group situations, and, from his experience with the patient on home visits, excursions to hospital canteens, etc., he is able to evaluate the patient's behavior in social circumstances and thus predict how he will relate to others in the community.

The attendant usually lives, or has lived, in the neighborhoods from which his hospital draws its patient population, a circumstance his better-paid professional colleagues do not usually share. As a result they often depend upon him to translate patients' cultural and subcultural group values, behaviors, linguistic metaphors,

Revised version of a paper read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

At the time this work was done, the authors were all members of the New York City-Long Island Regional Training Team, New York State Department of Mental Hygiene, where Dr. Ross is Director, Mr. Skerrett and Ms. Curry are Training Specialists 3, and Ms. Theodorou is Deputy Director. The other authors are currently with Meyer-Manhattan Psychiatric Hospital, Ward's Island, N.Y. 10035, where Dr. Talbott is Deputy Director, Mr. Marcus is Chief of Interdisciplinary Training, and Ms. Smith is Chief of the Harlem Unit.

The authors wish to acknowledge the contributions of Ernest J. Townsend, M.S.W., Program Analyst, New York State Department of Mental Hygiene, and Irwin Greenberg, M.D., D.M.Sci., former Director of Creedmoor State Hospital.

[1] Paraprofessionals are defined by various authors in different ways. Since the majority of nonprofessionally trained individuals in the mental health field are psychiatric attendants, we will use the two terms synonymously.

nonverbal cues, and conceptual frameworks into their own language. He also knows more practical ways of solving problems, which are often peculiar to his community and which can be utilized in the treatment plan. For example, an attendant in a hospital serving a black ghetto is aware that with many patients it is essential to involve the church in any plans for socialization and reentry into the community, since it is as important an institutional symbol for help in this population as the modern medical center is for the upper-middle-class white.

The attendant may be more willing to enter nonwhite communities than his professional colleagues. As a resident in the community, he constitutes a psychiatric "early warning system" for trends in social pathology, such as alcoholism, drug addiction, and gang behavior. He can also identify specific problem groups, such as homeless men, elderly persons, and runaways, who may not be receiving appropriate attention from existing delivery systems. In addition, he is often helpful in identifying individuals in trouble.

The attendant is more keenly aware than others of the survival issues facing patients both in the hospital and in the community, e.g., a patient who does not come to the aftercare clinic because he is often assaulted in his building's hallway. In the hospital the attendant is concerned with the patient's ability to organize and perform basic activities, and he can evaluate the expected reaction by the patient's family to the patient's functioning. No matter how adequately drugs control a patient's psychotic symptoms, if he cannot wash himself his family is unlikely to take him home.

Whether the treatment consists of milieu therapy, group or individual psychotherapy, psychopharmacology, behavior therapy, etc., the ultimate goal is behavioral change leading to the patient's discharge. Because the attendant is primarily concerned with functional improvement rather than personality change, he is usually the most accurate judge of the patient's current ability to handle the problems of everyday living. An illustrative example was that of a patient who was able to work effectively in occupational therapy, in rehabilitation activities, and on the ward, but who still harbored a paranoid delusion. The professional members of the treatment team were more concerned with the patient's psychopathology than with his ego functioning until the attendant pointed out his excellent ability to work, and plans were reformulated on the strengths rather than the deficits in his total personality.

The attendant is usually the only member of the team who will involve himself in improving the patient's level of functioning in activities of daily living by personally reeducating and rehabilitating the patient. He is the only person who will help a patient learn to tie his tie, brush his teeth, make his bed, and use cosmetics appropriately. His efforts in helping the patient appear presentable at a job interview may be just as important to the patient's recovery as the professional's efforts to diminish the psychopathology.

As a result of the attendant's interest in and involvement with these matters, he frequently sees events from the patient's point of view. He has a great ability to assess the realistic needs of a patient and communicate to the treatment team the patient's view of himself, his illness, the ward environment, and the outside world. This frame of reference often counterbalances that of administrators and professionals who, because of the roles in which they find themselves, tend to be more responsive to community, institutional, and bureaucratic pressures.

The hospital attendant is the patient's primary treatment agent, for better or for worse, because he is the most accessible and available person. The attendants on the ward, along with the patient population, must respond immediately to each patient many times a day, under differing circumstances and in varied situations. The paraprofessional is able to judge what responses are successful in dealing with specific patient behaviors, to make behavioral predictions about his patients, and to recommend appropriate staff responses to patient behaviors. This contribution to the pool of information gathered by the treatment team assists in its assessment of the effectiveness of various interactional responses and leads to the development of consistent therapeutic staff attitudes that will maximize behavioral change. For example, a patient who appeared very withdrawn and uncommunicative during the day was lively and talkative during the evening. An attempt was then made to make use of this observation to elicit information and conduct therapeutic activities in the evening, resulting in the patient's eventual improvement during the day.

Many professionals have a bias toward the success of certain types of treatment and a personal and professional investment in seeing the treatment they give as beneficial. The absence of theoretical bias in the paraprofessional's outlook allows him to assess the patient's condition realistically. He does not see a catatonic episode only as a "stage in treatment," but rather as a time during which the patient is unable to function. He may also see the patient more as he is in real life than does the professional, who sees the patient as accommodating himself to the role expectations of "patient." In addition, the paraprofessional's lack of investment in a particular theoretical framework or diagnostic rubric allows him to be open to undistorted observation and to be free from the need to place an interpretation on behavior or thought. Further, his lack of theoretical bias allows him to think of the patient as a total person and to plan for his needs beyond psychotherapy. An example of this was a young female patient whose behavior consisted of taking off her clothes and maintaining an extraordinarily messy ward area. Discussion at staff meetings centered on the underlying anality, exhibitionism, and aggression until an attendant pointed out that he did not know what her actions symbolized, but he had to deal with them, and he asked for recommendations for consistent staff attitudes to encourage more socially acceptable behavior.

We are not romanticizing the attendant as an intuitive genius but emphasizing the value of an unbiased approach. We believe that his lack of training may result in distortions in observing, reporting, or recommending, such as overly moralistic attitudes or seeing a patient's

actions as misbehavior rather than the result of mental illness. Practical clinical training is urged to decrease the possibility of such distortions.

TRAINING ATTENDANTS AS TRAINERS

Attendants have always assisted in the practical training of professionals and contributed to treatment programs. Psychiatrists, for example, are eager and willing to have paraprofessionals tell them what modes of treatment benefit their patients, and they often incorporate this information into the ongoing treatment plan. However, while professionals may be comfortable with the attendant in his role as the *assistant* to the physician, they may question his ability to relate as an expert in his own right, with skills equal in value to those of the professional.

To better understand this problem, we might begin by asking what makes people value what other people have to say. Certainly credentials are an important factor. This includes professional credentials such as degrees and certificates, experiential credentials attesting to expertise and skills, and status credentials such as titles and socioeconomic background, which reveal an individual's power in a social system. Personality traits and personal charm are also important ingredients. In addition, a common language, be it cultural, conceptual, metaphorical, verbal, or nonverbal, is important. A commonality of task in the work situation can be a powerful lever for receptivity of communications. If, for instance, the professional sees himself as the only person involved with treatment and sees the attendant's role as one involving only custodial care (e.g., menial tasks and housekeeping), he can discount the need for mutuality. If, however, the treatment task is seen as shared by everyone, the contribution of lesser or differently trained individuals becomes easier to accept. In addition, if the paraprofessional participates in the decision-making process regarding a patient, rather than being told what he is to do by the professional, he is more likely to feel a part of the treatment program and to contribute to its success. His inclusion in meetings also gives rise to the upward communication of staff opinions and information.

We see the paraprofessional's talents and skills as different from the professional's, rather than merely an extension of them. In training the attendant as a trainer, therefore, we stress the legitimation and sanction of these skills and informational talents rather than the incorporation of individuals into the mold of any particular discipline.

The training of attendants as trainers includes an emphasis on all the contributions they can make, as stated earlier. In addition, there is training in teaching concepts and methods; in institutional organization, administration, and bureaucratic structure; in communication, encompassing interpersonal, group, and administrative levels; in clinical methods, including treatment modalities; in system theory pertaining to the goals, philosophy, and workings of an institution; in community psychiatry; in group process and family organization; in problem solving and conflict resolution; and in using one's self as an objective observer and consultant.

THE PARAPROFESSIONAL TRAINER'S CONTRIBUTIONS

In his role as trainer the attendant offers a role model to the entire institution in which he works. Professionals become accustomed to listening to his observations, evaluations, and recommendations, and the ensuing trust that develops has a decided halo effect. The paraprofessional is able to help the professional learn to relate effectively with paraprofessionals and to assist the paraprofessional in communicating his special skills, talents, needs, and problems to the professional. He knows, moreover, not only what's "really going on" among the attendant staff (goofing off, formal and informal interactions, attitudes, behaviors, etc.) but also what's "really going on" on a ward or unit (staff resentment, treatment effectiveness, etc.). His experience and knowledge of ward structure, activities, and procedures allow him to offer help regarding schedules, time sheets, census reports, staffing patterns, medication procedures, etc. Because he has worked on a ward in a manner no professional usually has, he is able to assess what is appropriate to ask of the ward staff, what they are equipped to do, and where training is necessary if therapeutic effectiveness is to be improved.

The paraprofessional trainer's contributions to the entire treatment team can be invaluable. He serves as a bridge between the attendant and the professional staff and becomes a subcultural translator between professionals and paraprofessionals in much the same manner in which the ward attendant was described as a translator between patients and staff.

The paraprofessional trainer is also of great value to the paraprofessional staff. He understands them, identifies with them, and appreciates their resistance to change or the assumption of new duties without training, and he is able to pitch in and help, either because it is necessary at times or because he must establish his working credentials. Again, an example from our experience demonstrated this aspect. One of the paraprofessionals on the training team was attending a ward meeting when a patient appeared at the door with a nosebleed. No one moved, and the paraprofessional trainer left the meeting, took the patient to the washroom, and worked to stop the bleeding. On his return the staff was friendlier, and from that time on he was regarded as the only member of the training team who had "helped" the ward.

The paraprofessional trainer is also able to lend strength to the internal structure of the training team. Frequently he will reflect back to his professional cotrainers the attendants' side of conflicts existing in a particular team or institution, so that they can be identified, defined, and worked out and the methods of resolution can be communicated to the larger institution. For example, there was a vigorous disagreement between a professional and paraprofessional on the training team con-

cerning thefts in the hospital. The professional expressed his outrage at the rate at which sheets disappeared, only to be confronted by the attendant, who wanted to know why he wasn't concerned about doctors' "stealing time" by leaving early for private practice, conducting stock business over the phone, and taking long lunch hours. On reflection, they agreed that their argument mirrored a situation in the hospital in which both the professionals and attendants felt that the other group was cheating, and they used this in their next consultation at the hospital.

Another specific contribution of the paraprofessional trainer is his ability to convey to the training group the problems at the attendant/professional interface, which complements the professional trainer's information on the problems encountered at the professional/supervisory or professional/administrative interface. The paraprofessional trainer further contributes to the training team by working on a problem until it is solved, whereas the professional trainer tends to withdraw to contemplation or theorizing. At one point the training team was frustrated by a lack of progress in working on a particular unit, and the professional members spent hours, on and off the job, speculating about the interpersonal and organizational problems present. Meanwhile, the paraprofessional trainer continued to work on the unit and effected major changes because of his closeness to the personnel, his persistence in explaining his ideas, and his focus on the practical rather than the theoretical issues.

Antagonism of Guanethidine by Chlorpromazine

BY DAVID S. JANOWSKY, M.D., M. KHALED EL-YOUSEF, M.D., JOHN M. DAVIS, M.D., AND WILLIAM E. FANN, M.D.

Chlorpromazine was found to reverse the antihypertensive effects of guanethidine six times in use with four moderately or severely hypertensive psychiatric patients. Haloperidol and thiothixene caused similar effects. It is postulated that this drug-drug interaction occurs because chlorpromazine blocks the neuronal amine-guanethidine uptake pump, thereby denying guanethidine access to its site of action.

GUANETHIDINE SULFATE is a potent antihypertensive agent used widely in the treatment of hypertension. Of special importance to psychiatrists is the fact that it has a low incidence of depression as a side effect, because of its relative inability to cross the blood-brain barrier. Mitchell and associates (1, 2) have noted that tricyclic antidepressants, including imipramine, desipramine, and protriptyline, administered in clinically efficacious doses, reverse the clinical effects of guanethidine in hypertensive patients. In our laboratory, we have shown that doxepin, in doses of 200–300 mg./day, reverses guanethidine's antihypertensive effects (3).

Tricyclic antidepressants inhibit the neuronal uptake of norepinephrine and serotonin (4). In a similar way, they inhibit the neuronal uptake of a wide variety of ring-substituted bases, including guanethidine sulfate and related antihypertensive agents (4–6). Because of this inhibition, access of these substances to their intraneuronal site of action is presumably blocked and they thus fail to exert their hypotensive action. Animal studies have indicated that the phenothiazines, including chlorpromazine, also block guanethidine's antihypertensive action (7), presumably by the same mechanism as in the case of the tricyclic antidepressants (5, 7).

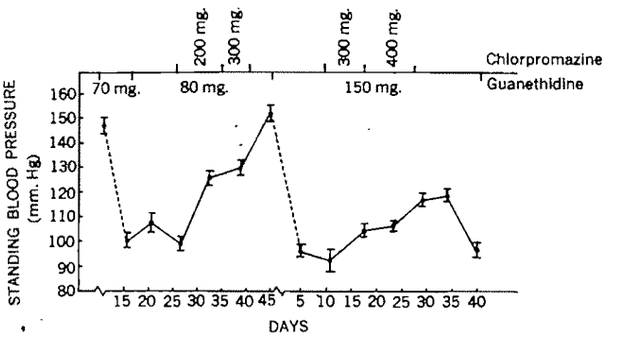
Since chlorpromazine and related antipsychotic agents are frequently used in the treatment of psychiatric patients who also have hypertension, we felt it important to evaluate whether or not chlorpromazine blocks the ac-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Drs. Janowsky, El-Yousef, and Davis are with Vanderbilt University School of Medicine, Nashville, Tenn. 37203, where Dr. Janowsky is Associate Professor of Psychiatry and Assistant Professor of Pharmacology, Dr. El-Yousef is Assistant Professor of Psychiatry and Instructor of Pharmacology, and Dr. Davis is Professor of Psychiatry and Assistant Professor of Pharmacology. Dr. Fann is Associate Professor of Psychiatry, Duke University School of Medicine, Durham, N.C.

This work was supported in part by Public Health Service grants GM-15431 from the National Institute of General Medical Sciences and MH-11468 from the National Institute of Mental Health and by research support from the State of Tennessee Department of Mental Health.

FIGURE 1
*Reversal of Guanethidine's Hypotensive Effect by Chlorpromazine in Patient J.H.**



*Each point represents the standing diastolic blood pressure averaged over a period of days (mean ± S.E.M.).

tion of guanethidine, when administered in doses used clinically, and to compare these effects with those of related antipsychotic compounds.

METHOD

The patient group studied consisted of one male and three female chronically hospitalized adult psychiatric inpatients (age range: 47–62) who were admitted to the clinical unit of the Tennessee Neuropsychiatric Institute. All the patients consented to participate in the investigation. They had persistent hypertension of a moderate to severe degree. On admission their standing systolic blood pressures ranged from 230 to 172 mm. Hg and their diastolic blood pressures from 150 to 110 mm. Hg. All patients were evaluated by an internist and diagnosed as suffering from essential hypertension.

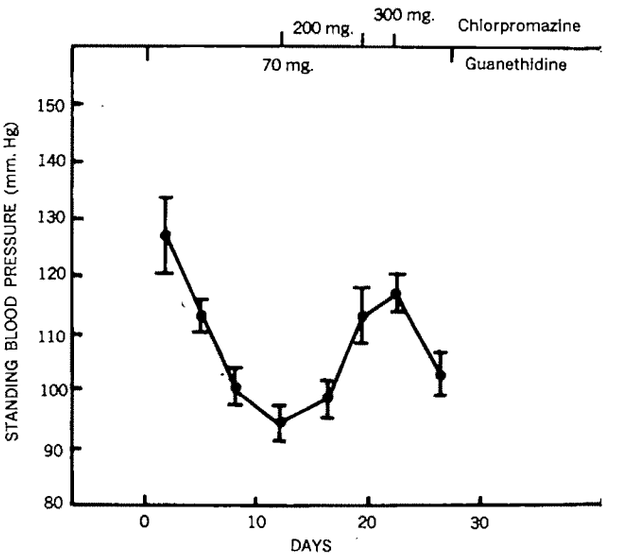
The patients were admitted to the research ward and taken off all drugs for at least 19 days. After a clinically effective dosage of guanethidine was determined, each patient's blood pressure was stabilized on that dosage of guanethidine sulfate for a period of at least seven days prior to the administration of the proposed antagonist. Chlorpromazine, ranging in total daily dosage from 100 to 400 mg., administered three times daily in divided doses, was then added to the guanethidine regimen for a period of no less than 12 days. Chlorpromazine was then discontinued and guanethidine treatment was continued for a postantagonist phase of nine days or longer, using the same dose of guanethidine. Chlorpromazine was reintroduced in two cases. In addition, haloperidol was introduced and subsequently withdrawn in two patients. Also, haloperidol was introduced, withdrawn, and followed later by thiothixene administration in one patient. Thus, in six instances, chlorpromazine was used as the antagonist, haloperidol was used three times, and thiothixene was used once.

Measurements of systolic and diastolic blood pressure were made with the patients in the standing and supine positions on a four-times-daily basis throughout all study periods, and a mean blood pressure, plus or minus the standard error of the mean, for a given experimental phase was calculated. Experimental phases in the cases in which chlorpromazine was used as an antagonist were divided into: 1) a phase in which hypertension was controlled by guanethidine, consisting of the last seven days in which guanethidine alone was administered; 2) a guanethidine plus antagonist phase, consisting of the last seven days during which both guanethidine and chlorpromazine were administered; 3) an antagonist withdrawal phase, lasting at least five days; and 4) a late guanethidine treatment phase. Student's t test was utilized to compare each experimental phase with the subsequent experimental phase. Similar phases of somewhat different lengths were utilized when thiothixene and haloperidol were used as guanethidine antagonists. In addition, consecutive five- to seven-day averages of standing diastolic blood pressure ± standard errors of the mean were calculated for each patient for whom chlorpromazine was used as an antagonist.

RESULTS

Patients were admitted to the ward and taken off all drugs, and their blood pressure was lowered with guanethidine. Chlorpromazine was then administered. Analysis of the data indicated that chlorpromazine in doses ranging from 100 mg./day to 400 mg./day significantly

FIGURE 2
*Reversal of Guanethidine's Hypotensive Effect by Chlorpromazine in Patient N.H.**



*Each point represents the standing diastolic blood pressure averaged over a period of days (mean ± S.E.M.).

TABLE 1
Effectiveness of Chlorpromazine in Reversing Guanethidine's Antihypertensive Effects in Four Patients: Standing Blood Pressure

Patient	Daily Dosage		Phase 1 Last Seven Days of Guanethidine Alone	Phase 2 Last Seven Days of Guanethidine + Chlorpromazine	Comparison of Phases 1 and 2	Phase 3 Early Chlorpromazine Withdrawal Phase
	Chlorpromazine	Guanethidine				
J.H., trial 1	400 mg.	80 mg.	145±3/105±3	176± 3/127±2	p<.00001/p<.00001	210±5/150±3
J.H., trial 2	400 mg.	150 mg.	131±5/ 95±3	138± 2/104±2	n.s./p<.0006	150±3/114±2
N.H.	200–300 mg.	70 mg.	158±6/ 94±3	177± 9/112±5	p<.05/p<.002	191±5/116±3
J.L.	400 mg.	60 mg.	140±9/ 73±9	147± 3/115±2	n.s./p<.0001	170±4/125±3
S.L., trial 1	400 mg.	60 mg.	121±6/ 97±4	179± 5/118±4	p<.00001/p<.00003	160±7/111±6
S.L., trial 2	100 mg.	90 mg.	113±6/ 82±4	153±11/105±7	p<.003/p<.006	150±5/108±3
Mean			134/ 91	161/113		171/120

reversed the antihypertensive effects of guanethidine in all six instances in which it was used as an antagonist. Significant but less dramatic reversals occurred when haloperidol and thiothixene were used.

Figure 1 illustrates the time course of changes in standing diastolic blood pressure in patient J. H. His blood pressure was initially lowered by guanethidine. Chlorpromazine, after a short lag phase, caused a partial guanethidine antagonism. Withdrawal of chlorpromazine resulted in a rebound of the blood pressure to pretreatment levels. Institution of antihypertensive treatment (including 150 mg./day of guanethidine) then lowered the blood pressure, which again slowly increased, though to a lesser extent than during the first trial, after chlorpromazine was again added. Withdrawal of chlorpromazine again caused an initial increase in blood pressure, followed by a fall to clinically desirable levels.

Figure 2 illustrates the time course of changes in standing diastolic blood pressure in patient N. H. This patient's standing diastolic blood pressure was initially controlled with guanethidine. This effect was antagonized partially by chlorpromazine and a further, although insignificant, increase in blood pressure occurred upon early withdrawal of chlorpromazine. Later, with continuing guanethidine treatment, the patient's blood pressure fell significantly to clinically desirable levels.

Table 1 summarizes the changes in standing blood pressures occurring during specific experimental phases consisting of: 1) the last seven days in which hypertension was controlled with guanethidine, 2) the last seven days of administration of guanethidine plus chlorpromazine, 3) the early chlorpromazine withdrawal phase, and 4) the late guanethidine treatment phase. As can be seen, a highly significant increase in the standing diastolic blood pressures occurred in all cases during chlorpromazine treatment. A rise in standing systolic blood pressures occurred during chlorpromazine treatment in all cases, and this change was significant in four of the six studies.

The reversal of guanethidine's action occurred between a few days to more than a week after chlorpromazine was started. In three of the six studies, a rebound increase in blood pressure occurred during the chlorpromazine withdrawal phase. Since it was clinically undesirable to reverse the antihypertensive effect of guanethidine to a degree that might result in a dangerous or prolonged elevation of blood pressure, we terminated the studies after a definite and statistically significant reversal in standing diastolic blood pressure was demonstrated. In all cases, this reversal was clearly statistically significant ($p < .002$ to $p < .00001$) and in most cases it was also clinically significant. The increase in standing blood pressures averaged 27/22 mm. Hg for the six reversals.

The supine blood pressure findings were similar to those for the standing blood pressure. When chlorpromazine was added, blood pressure rose significantly, either during the administration of chlorpromazine or after its

TABLE 2
Effectiveness of Haloperidol and Thiothixene in Reversing Guanethidine's Hypotensive Effects: Standing Blood Pressure

Patient	Antagonist		Daily Dosage of Guanethidine	Guanethidine Phase	Guanethidine + Antagonist Phase	Comparison of Phases
	Drug	Daily Dosage				
J.H., trial 3	Haloperidol	9 mg.	150 mg.	132±3/95±2	149±5/ 99±2	p<.003/p<.086
S.L., trial 3	Haloperidol	6 mg.	90 mg.	125±6/86±4	148±5/100±3	p<.01/p<.01
J.L., trial 2	Haloperidol	8 mg.	60 mg.	138±5/91±3	154±4/100±2	p<.005/p<.02
J.L., trial 3	Thiothixene	60 mg.	60 mg.	126±3/87±2	156±5/110±3	p<.00001/p<.001

Comparison of Phases 2 and 3	Phase 4 Late Guanethidine Treatment Phase	Comparison of Phases 3 and 4
p<.01/p<.0002	132±3/ 95±2	p<.001/p<.00001
n.s./n.s.	164±9/103±4	p<.01/p<.005
p<.00005/p<.02	120±3/ 86±2	p<.00001/p<.00001
p<.04/n.s.	113±6/ 82±4	p<.00001/p<.0002
n.s./n.s.	125±6/ 86±4	p<.003/p<.0003
	130/90	

withdrawal. A significant rebound rise in systolic and diastolic blood pressures occurred in three of the six trials after chlorpromazine was discontinued, with the blood pressures eventually falling during continued guanethidine treatment.

We would emphasize that when repeat studies were done with patients who had shown a marked reversal of guanethidine's hypotensive effect, we increased the dose of guanethidine and terminated the experiment as soon as a minimal repeat reversal of standing diastolic blood pressure was seen, so as to expose the patients to as little risk as possible. This modification may explain why no reversal of supine blood pressure occurred during the repeat administration of chlorpromazine to patients J. H. and S. L.

Table 2 illustrates the effects of haloperidol and thiothixene on guanethidine's hypotensive effects. As can be seen, significant but relatively small increases in standing systolic and diastolic blood pressures occurred with haloperidol administration in three instances and with thiothixene in one.

COMMENT

The mechanism of action underlying the antagonism of guanethidine's hypotensive effects by antipsychotic agents is probably the same as that by which we, using doxepin (3), and others, using tricyclic antidepressants (1, 2, 6), have shown that these drugs antagonize guanethidine's hypotensive effects, namely by blockade of the amine uptake pump.

In order to more directly verify that antipsychotic drugs do cause this antagonism by inhibiting the amine uptake pump, we utilized a technique previously described (8) for studying the amine uptake pump in broken-off nerve endings (synaptosomes) in rat brain (8). We incubated antipsychotic agents and tricyclic antidepressants at 37C for 15 minutes with H^3-metaraminol, a nonmetabolized norepinephrine-like amine. As expected, the tricyclic antidepressant protryptyline inhibited metaraminol uptake (uptake = 38.2 ± 3.3 percent at 1×10^{-4}M and 47.5 ± 2.6 percent of the control values at 1×10^{-5}M). Similarly, the uptake pump was inhibited by the antipsychotic drugs chlorpromazine (uptake = 43.6 ± 1.0 percent at 1×10^{-4}M and 58.9 ± 1.8 percent of the control values at 1×10^{-5}M), haloperidol (uptake = 40.8 ± 1.5 percent at 10^{-4}M and 74.6 ± 1.6 percent of the control values at 1×10^{-5}M), and thiothixene (uptake = 49.1 ± 2.6 percent at 1×10^{-4}M and 96.3 ± 2.7 percent of the control values at 1×10^{-5}M) and by the antidepressant drug doxepin (uptake = 64.6 ± 0.5 percent at 1×10^{-4}M and 71.8 ± 8.6 percent of the control values at 1×10^{-5}M).

The fact that drugs of five different chemical families inhibit the synaptosomal membrane pump and clinically reverse the hypotensive effects of guanethidine strengthens the likelihood that the reversal occurs because of inhibition of the amine uptake pump. Antipsychotic agents may also block alpha receptors, but our data suggest that, in the dosage range utilized here and clinically, the ability to block uptake in the membranes outweighs their ability to block alpha receptors.

On a milligram-for-milligram basis, chlorpromazine seems to be a less potent antagonist of guanethidine than are the tricyclic antidepressants (1, 2). However, the doses of chlorpromazine (400–800 mg.) used to treat psychotic patients are relatively higher than the doses of tricyclic drugs (100–150 mg./day) used to treat depressed patients.

Although the degree of reversal with haloperidol and thiothixene was generally smaller than that with chlorpromazine, the period of drug administration was generally shorter than that for chlorpromazine. Thus, the effect on blood pressure for equivalent periods of time for the three drugs was not evaluated. However, in the case of patient S. L., chlorpromazine caused a greater reversal after six days than did haloperidol, thus indicating that haloperidol and thiothixene are less potent reversers of the effects of guanethidine than is chlorpromazine.

Our data have certain practical implications. First, it is likely that antipsychotic agents other than chlorpromazine, haloperidol, and thiothixene have similar effects, since each of the agents tested by us is representative of one of the three major chemical categories of antipsychotic agents used clinically. Thus, it would seem useful to utilize other hypertensive agents than guanethidine when antipsychotic agents are administered. To this end, the data of Mitchell and associates (2) suggest that methyl-dopa is not concentrated by the membrane pump. This agent may thus be useful in the treatment of hypertensive psychiatric patients. If guanethidine is the preferred drug, our data suggest that the drug antagonism may be minimized by increasing the guanethidine dosage. Certainly, our data indicate that blood pressure should be carefully monitored when any antipsychotic agent and guanethidine are used together.

In conclusion, we have demonstrated that chlorpromazine reversed guanethidine's antihypertensive effects six times in four consecutive cases. This information, plus data from animal studies demonstrating that chlorpromazine is an inhibitor of the neuronal uptake pump

and information indicating that chlorpromazine blocks guanethidine's hypotensive effects in animals, provides evidence that a drug-drug interaction occurs that causes reversal of guanethidine's antihypertensive effect.

REFERENCES

1. Mitchell JR, Arias L, Oates JA: Antagonism of the antihypertensive action of guanethidine sulfate by desipramine hydrochloride. JAMA 202:973–976, 1967
2. Mitchell JR, Cavanaugh JH, Arias L, et al: Guanethidine and related agents, III: antagonism of drugs which inhibit the norepinephrine pump in man. J Clin Invest 49:1596–1604, 1970
3. Fann WE, Cavanaugh JH, Kaufmann JS, et al: Doxepin: effects on transport of biogenic amines in man. Psychopharmacologia 22:111–125, 1972
4. Iversen LL: The inhibition of noradrenaline uptake by drugs. Adv Drug Res 2:1–46, 1965
5. Koe BK, Constantine JW: Blocking H^3-norepinephrine uptake and some guanethidine-induced effects with tricyclic psychotherapeutic drugs. Arch Int Pharmacodyn Ther 195:71–80, 1972
6. Mitchell JR, Oates JA: Guanethidine and related agents, I: mechanism of the selective blockade of adrenergic neurons and its antagonism by drugs. J Pharmacol Exp Ther 172:100–107, 1970
7. Stone CA, Porter CC, Stavorski JM, et al: Antagonism of certain effects of catecholamine-depleting agents by antidepressant and related drugs. J Pharmacol Exp Ther 144:196–204, 1964
8. Janowsky DS, Davis JM, Fann WE, et al: Angiotension effect on uptake of norepinephrine by synaptosomes. Life Sci 11:1–11, 1972

Effectiveness of Drug Education Programs for Secondary School Students

BY SUE C. WEAVER, ED.D., AND FOREST S. TENNANT, JR., M.D.

In order to evaluate the effectiveness of a drug education program, an intensive and costly three-week drug education course was given to 452 eighth-grade students. A similar group of eighth-graders who received minimal drug education served as controls. While the students in the experimental group demonstrated superior knowledge of drugs, there was no significant reduction in their drug taking. A follow-up survey of the experimental students done nine months later revealed that their drug use increased despite the intensive program.

DESPITE NATIONWIDE ATTEMPTS to disseminate drug information, the problem of drug abuse continues to rise, according to surveys (1–3). The social implications of this problem have made parents, educators, professionals, and civic leaders aware of an urgent need for effective drug education programs in our schools.

Evaluations of the effectiveness and outcomes of drug abuse programs in school systems, however, have seldom been reported (4). Antismoking programs for secondary school students have been evaluated but have usually failed to influence smoking behavior (5, 6). Tennant and associates (4) found that drug education classes given by physicians to U.S. Army soldiers resulted in reduced drug consumption in casual drug users and decreased drug-related hospital admissions. Soldiers who were regular drug users, however, did not alter their drug use as a result of the classes.

In order to determine whether intensive drug education can effectively reduce or prevent drug abuse in secondary schools, a one-year longitudinal study of eighth-graders was conducted.

METHOD

In 1969, two groups of eighth-grade students from two separate school districts in the greater Houston area were selected for study. One group of 452 students from three schools in one school district served as the experimental group, and 380 students from three high schools in a different school district similar in socioeconomic status served as the control group.

All of the students in the experimental and control groups received drug information during the 1969 school year: 1) from one or two all-school assemblies where they listened to a guest panel consisting of a physician, pharmacist, and lawyer, and 2) by watching drug education films. In 1969, this format was routinely practiced by all of the schools in these districts.

In order to determine whether a more intensive and costly drug education program leads to increased knowledge of drugs and decreased drug consumption, the experimental group was given an additional three-week

Dr. Weaver is Consultant, Instructional Services and Drug Abuse Education, the Education Service Center, Houston, Tex., and Dr. Tennant is Director, UCLA Methadone Treatment Program, and a resident, Department of Preventive and Social Medicine, UCLA School of Medicine, Los Angeles, Calif. 90024. Address reprint requests to Dr. Tennant.

drug education course taught by specially trained physical education teachers. The program utilized a commercially prepared purchased format consisting of advanced methods including programmed texts, films, case studies, and role-playing by students to generate enthusiasm, decision making, involvement, and sensitivity to human problems. The program cost $4.00 per student. Parents attended one special session to discuss drug issues and to ask questions about their personal involvement in the program.

At the conclusion of the intensive three-week program, the experimental and control groups were administered two anonymous questionnaires. One was an achievement test to assess the students' knowledge about the pharmacologic, legal, and medical implications of drug abuse. This test consisted of 50 questions, each of which had an equal value. The second questionnaire contained 18 questions and inquired about the prevalence of drug use, whether the education program had influenced drug taking, and the students' preference for drug curriculum in education.

Since no time limits were set for the completion of each survey only questionnaires with fewer than two unanswered questions in either survey were accepted for study.

Nine months later, when the students in the experimental group had entered high school (ninth grade), the same two questionnaires were again anonymously administered to them. Of the original 452 students, 327 could be located for the retest. The purpose of the resurvey was to determine the students' retention of drug knowledge and whether the intensive education program had influenced drug use. Questionnaires with more than two unanswered questions were again discarded.

RESULTS

A total of 267 (68 percent) of the respondents in the experimental group and 288 (91 percent) of 315 of the respondents in the control group felt that they should have been given additional drug information when they reached high school ($p<.001$). In response to a question concerning preference for method of drug education 212 (55 percent) of 381 in the experimental group and 236 (80 percent) of 293 in the control group requested all-school assembly programs with guest speakers and films as opposed to classroom instruction, literature, parent involvement, or a drug information center organized by students.

On the 50-item achievement questionnaire, the experimental group demonstrated superior knowledge of drugs by correctly answering a mean of 29.99 questions, while the control group correctly answered a mean of 18.15 questions ($p<.05$). Despite a demonstration of superior drug knowledge, 50 (12.5 percent) of 402 of the students in the experimental group currently considered themselves to be experimental or casual drug users, while only 13 (4.1 percent) of 316 of the students in the control group did ($p<.001$). A total of 18 (4.5 percent) of 402 of the students in the experimental group indicated they used drugs five or more times a week, while 8 (2.5 percent) of 316 of the students in the control group indicated the same frequency of use (difference not significant).

TABLE 1

Prevalence of Drug Use in the Experimental Group in Grades Eight and Nine (in Percentages)

Category	Grade Eight (N=402)	Grade Nine (N=284)	Significance
Experimental or casual drug use	12.5	18.0	$p<.05$
Drug use more than five times a week	4.5	3.9	n.s.

A total of 19 (4.7 percent) of 402 of the students in the experimental group and eight (2.5 percent) of 316 of the students in the control group stated they stopped drug experimentation due to information received from their respective school drug programs (difference not significant). In the experimental group and in the control group 41 percent each felt that information received in school had helped them convince peers not to use drugs.

In the nine months following the intensive three-week instruction, the experimental group showed a reduction in their knowledge of drugs on the achievement test. The 279 students from the experimental group who were available for retesting and who had valid questionnaires correctly answered a mean of 27.32 questions out of a possible 50, compared with a previous mean of 29.99 correctly answered questions immediately after the course ($p<.05$). Assessment of the prevalence of drug use in the experimental group at this time indicated an increase in experimental and casual drug use, but not in regular use (more than five times per week; see table 1). The percentage of students in this group who used drugs casually or experimentally increased from 12.5 percent in the eighth grade to 18 percent in the ninth grade ($p<.05$). Regular drug usage of more than five times a week did not change significantly; it was 4.5 percent in the eighth grade and 3.9 percent in the ninth grade.

DISCUSSION

A key issue in this study is that despite an intensive and costly drug education program that utilized advanced technological methods of communication, role-playing, and didactic learning, it could not be demonstrated that the program reduced drug use or prevented experimentation with drugs. The experimental group of eighth-grade students did demonstrate, however, greater knowledge of drug abuse than the matched control group. In addition, a statistically equal percentage of control students (who attended only one or two all-school assembly programs) and experimental students (who attended the assemblies

plus the intensive three-week course) indicated that they had stopped using drugs due to their respective programs. It is interesting to note that the majority of students in both groups preferred the assemblies with guest speakers as a mode of drug education to a drug information center organized by students, school-distributed literature, parent involvement, or classroom instruction.

Some loss of drug knowledge in the experimental group occurred within the year following the intensive education course. This indicates that drug education may need to be intermittently repeated if a high degree of knowledge is to be retained.

Evaluation of drug education programs is difficult and must necessarily rely on imprecise methods such as questionnaire techniques or hospital admissions. Nevertheless, critical evaluations of the effectiveness and results of drug education programs are necessary to identify beneficial modalities. This study indicates that costly and concentrated drug education efforts may not be extremely effective or necessarily warranted for secondary school students.

REFERENCES

1. Gosset JT, Lewis JM, Phillips VA: Extent and prevalence of illicit drug use as reported by 56,745 students. JAMA 216:1464–1470, 1971
2. Johnson KG, Donnelly JH, Scheble R, et al: Survey of adolescent drug use: sex and grade distribution. Am J Public Health 61:2417–2432, 1971
3. Chambers CD: An assessment of drug use in the general population, in Treatment and Rehabilitation of Narcotic Addicts. Washington, DC, US Government Printing Office, 1971, pp 473–638
4. Tennant FS Jr, Mohler PJ, Drachler DH, et al: Effectiveness of drug education classes. Am J Public Health (in press)
5. Reid EL, Stove DB: Smoking behavior change among junior high school youth. Journal of Drug Education 1:223–234, 1971
6. Monk M, Tayback M, Gordon J: Evaluation of an antismoking program among high school students, in Program Evaluation in the Health Fields. Edited by Schulberg HC, Shelson A, Baher F. New York, Behavioral Publications, 1970, pp 345–359

Youth Psychopathology and Family Process Research

BY LEONARD HOLLANDER, M.D., AND EMIL KARP, M.A.

The authors examine methods and summarize outcomes of interaction studies on the families of disturbed youths. Their own series of experiments is designed to yield interaction and perception measures using comparison groups of nonclinic and clinic families, with subcategories of clinic families based on the psychopathology of the youngster.

A SELECTIVE REVIEW of the major recent research literature in family interaction was undertaken in a quest for the implications this research might have for understanding the role played by the family in the development and maintenance of psychological disturbance in the child. A related question concerns the characteristics of the child in determining his being "chosen" and continuing as the family member who is disturbed. In other words, how do the child and his family mutually influence each other's psychological functioning and behavior? How are intrapsychic and interpersonal events related in the transactional interface between child and family?

This report focuses on a body of work that seems relatively sophisticated in terms of experimental design and statistical data analysis. Two types of research will be surveyed: 1) a comparison of "normal" and "abnormal" families and 2) a comparison of one or more diagnostic categories (such as schizophrenics and delinquents) with normal controls or multiple comparisons among several differentiated groups.

COMPARISONS OF NORMAL AND ABNORMAL FAMILIES

Generally, data are gathered from family tasks that may be divided into five categories involving free interaction, a structured interview, a questionnaire, family games, and family projective tests.

In free interaction, the family is asked to discuss such topics as a previously tape-recorded family interaction session after listening to it. In a structured interview, fewer degrees of freedom are allowed and such questions

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

At the time this work was done the authors were both with the Georgia Mental Health Institute, Atlanta, Ga., where Dr. Hollander was Chief and Mr. Karp was Research Associate, Child Psychiatry Research Laboratory. Dr. Hollander is now Associate Professor and Coordinator of Family Studies, Department of Psychiatry, Rutgers Medical School, University Heights, Piscataway, N.J. 08854.

may be asked as, "What do you think are the main problems in your family?" or "How did you two meet?" Instructions like "Plan something together" may be given.

Questionnaire tasks usually cover such topics as attitudes and preferences regarding family life, family values, and family interests. They yield quantifiable data from the answers themselves and also may be used to study family interaction. For the latter purpose, after each family member has filled out the questionnaires individually, their differences in answers are presented to the family to resolve together. The process of reaching agreement on a joint family questionnaire protocol is observed and recorded and subsequently coded into categories of interaction by trained raters. This revealed-differences method was first developed by Strodtbeck in 1951 (1). In Ferreira's modification (2), the differences are not revealed to the family before the interaction takes place. Prior knowledge of the answers of individual members of the family thus does not influence their joint effort in this adaptation, known as the unrevealed-differences technique.

In family tasks and games, measures can be quantified to augment data from verbal interaction. Such measures avoid the errors inherent in using judges to sort the data into categories and are not subject to the influences of a priori hypotheses that would otherwise be possible in content analysis. Haley (3) devised a game in which coalitions could be formed by family members pressing buttons simultaneously. Bodin (4) used a modified Parcheesi board to study family coalition making. Ravich (5) reported on an Interpersonal Game Test in which each partner maneuvers a small electric train on a track that requires the choice of a collision course or other alternatives. He classified playing strategies as competitive, alternating, dominant-submissive, and mixed. Reiss and Sheriff (6) have computer-automated a task requiring family members to solve pattern-recognition problems while sitting at teletype machines.

Traditional as well as novel projective techniques used to assess family interaction include: Thematic Apperception Test (TAT) cards in family story-making ventures (7); the Family Relations Indicator, a set of ambiguous family pictorial stimuli (8); and a ten-card series of pictures portraying family members with ambiguous racial characteristics in which the scenes are familiar, interesting, and concrete (9).

The Rorschach can be given to an entire family. Individual protocols can be compared with the joint family product in terms of content analysis or the formal elements of the test (10). Singer and Wynne matched individual family members' protocols with those of the "identified patient" in a blind procedure and subsequently used their technique in a broad research program (11). Family art productions provided the material for Kwiatkowska's study of interaction and characteristics in a family context (12). Schulman, Shoemaker, and Moelis devised a verbal, imaginative, storytelling task for the family to complete (13).

Despite extensive family research, published studies shed meager light on the connections between particular types of youth psychopathology and differential forms of family process. Most of the techniques that have been used to study family interaction have been applied in research designs that compare normal families with either a specific category of abnormal families, such as schizophrenic, or with abnormal families in general, which consist of the range of psychopathologies. Because a normal control group may have a different task-performing set while being studied, the testing of hypotheses about psychopathology requires comparisons using other control groups in addition to normal subjects. Thus, differences in task-performance set can be minimized when families have in common an orientation pointing to problems in a child.

As opposed to normal families, abnormal families distribute their statements more evenly among family members (14), have fewer nonlexical within-family speech similarities (15), require more time to perform a task, are more silent, exchange less information, agree less, and fulfill each other's needs less (16–18). Abnormal families exhibit significantly fewer cases of three-way alignment between father, mother, and youth and significantly greater cases of two-way alignment between parents than do normal families (19). Differences between normal and abnormal families have been found on several indices of power (20, 21). However, no clear-cut pattern of parental dominance was reported in several other studies (22, 23). Family perceptions of adjustment and satisfaction have been used to discriminate between normal and abnormal families (24).

COMPARISON BY DIAGNOSTIC CATEGORIES

Compared with normals, schizophrenic families strive for an agreed-upon interpretation of the environment rather than a correct one (25); are more ambiguous, less adequate in communicating instructions, and less imaginative (26); spend less time in coalition; and have more difficulty planning (27).

Delinquent versus normal comparisons indicate more parental rejection and hostility (13), less father-son agreement and less maternal influence (28), and more stable patterns of differential parental dominance in families with delinquent children (29). Maternal dominance and marital strife characterize the neurotic-disturbed delinquent's family. Lack of effective parental control marks the unsocialized-psychopathic delinquent's family. Father dominance without major marital disagreement typifies the socialized-subcultural delinquent's family.[1] The socialized-subcultural delinquent daughter and the unsocialized-psychopathic delinquent daughter are inappropriately assertive and disruptive within the family, particularly toward the father (29).

Very little attention has been given to studying the families of youths diagnosed as neurotic. A few studies

[1] "Socialized-subcultural" refers to behavior reflecting the social norms of the cultural subgroup.

have compared psychopathological families of various diagnostic categories. Parents of schizophrenics have been found to be more overinvolved, rigidly demanding, and parent-need oriented in their TAT stories than parents of alcoholics and delinquents (30). Hostility expressed in TAT stories is higher in schizophrenic families than in delinquent and maladjusted families (7). Schizophrenic families show less information exchange and more silence than families of delinquents and families of maladjusted youngsters on an unrevealed-differences task (18). They also make a higher percentage of "chaotic" final responses (family decisions contrary to the individual wishes of every family member) than other groups of abnormal families (16).

A number of novel categorizing systems have been used by Goldstein and associates (31, 32) and by McPherson (33). These investigators examined the interactions of families containing disturbed adolescents, classifying the adolescents empirically into subgroups based on dimensions of activity (active-passive) and the locus of problem expression (inside family-outside family). The resultant groupings were: 1) aggressive-antisocial, 2) active family conflict, 3) passive-negative, and 4) withdrawn. Skin resistance data revealed that the aggressive-antisocial adolescents and the passive-negative adolescent groups whose problem sphere extended beyond the home were consistently less reactive than the active-family-conflict and withdrawn groups who shared a home-locus conflict arena. The most recent paper by Alkire and associates (34) reported on this same population. Parents of adolescents whose problem sphere was outside of the home relied on their legitimate rights as parents to require behavior change of the adolescents. Parents of adolescents whose problems were manifest in the home setting avoided these direct power-assertive techniques in favor of indirect techniques of stimulating conformity by information seeking (asking opinions and restrictive [i.e., yes or no] questions likely to arouse feelings of guilt).

Riskin and Faunce (35) grouped families in ways that would allow for questions about the differences between families in which the identified patient is a child and families that do not single out a particular child to serve as a "family symptom." The groups they used were multiproblem families, constricted families with two or three labeled problems, families with child-labeled problems (delinquency or under-achievement), families with significant problems (not labeled), and normal families.

Studies that have discriminated among several groups of families distinguished by the diagnosed psychopathology of the youth are few and do not give an organized picture of both the characteristic types of interactions and the perceptions held by family members within diagnostic categories.

THE GEORGIA INSTITUTE PROJECT

A project now being conducted in the Child Psychiatry Research Laboratory of the Georgia Mental Health Institute attempts to overcome some of the difficulties of earlier research by comparing families of differing psychopathology on several measures of family interaction and perception. Families are studied that have as a designated patient a youth between the ages of eight and 13 (the 14- to 18-year-old age group will be examined later). Each of the following categories is included: 1) clinic families of (a) neurotic children, (b) schizophrenic children, (c) children with minimal brain dysfunction, (d) children with behavioral problems (not brain dysfunction), and (e) physically disabled children; and 2) nonclinic families (normal).

The research is essentially exploratory and employs traditional techniques tried in other contexts as well as techniques that seem promising but have not been used with families. The adequacy of particular family tasks in generating discriminatory data is also being investigated.

Differential parental perceptions of the child's behavior are elicited by independent answers on two behavior checklists. The Missouri Behavior Checklist (36) has norms for dimensions of aggression, inhibition, activity level, sleep disturbance, somatization, and sociability. A supplementary checklist devised for this current project distinguishes behavior within and outside the home.

The child is seen by himself for a brief interview and administration of the Bender-Gestalt and Peabody Picture Vocabulary Tests, which are gross measures of perceptual-motor functioning and verbal intelligence.

The checklist responses, interview with the child, and test results will be used in an attempt to fashion a classification system alternative to psychiatric diagnosis for relating data on the child to family process findings.

Four tasks are presented to each family, i.e., to the mother, father, and named problem youngster. The first is a revealed-differences task in which each family member individually answers a questionnaire of multiple-choice format with ten choices in each of seven relatively neutral areas (choice of two-tone color combinations for the family's next car, supper menu preferences, etc.). The differences are then revealed to them and they are asked to discuss each item until they reach either a complete agreement on a solution or an impasse. The second is a family space task that requires individual family members to place figures of a man, woman, and child on a piece of paper in a family grouping. The third test is a family Thematic Apperception Test consisting of one set of three standard TAT cards. The family is asked to unite the cards into one theme telling a story. For the final test, families are given the task of discussing some family difficulties or problems, arriving at two things they would most like to see changed.

Tape-recordings and observations of the family through a one-way screen are made while they perform their assignments. How the family resolves individual differences to arrive at a common goal is a prime focus of study.

Very similar measures are derived from the revealed-differences task, family Thematic Apperception Test, and discussion of family problems tasks. From typed scripts and tape-recordings, measures are made of who talks to

whom, decision time, two- and three-way alignments, dominance, conflict, and nonlexical speech similarities. Particular to the revealed-differences task are measures of spontaneous agreement and choice fulfillment. On the family Thematic Apperception Test, additional measures consist of content analysis of the stories in regard to four dimensions: affects, interpersonal relationships, outcomes, and sequence analyses. In the family space task, distances between figures for each person as well as an average family score will be computed.

Statistical techniques employed to distinguish the various population groupings and diagnostic categories are analyses of variance and chi-square tests of independence.

DISCUSSION

The aim of our initial effort was to survey previous experimental work preparatory to planning a set of family interaction projects. Particular emphasis was placed on methodology and outcome. The summary nature of this report precludes detailed consideration of the problems confronting the investigator. An extensive evaluative review of family interaction research by Riskin and Faunce (37) explores the many complex issues involved.

REFERENCES

1. Strodtbeck F: Husband-wife interaction over revealed differences. Am Sociol Rev 16:468–473, 1951
2. Ferreira A: Decision-making in normal and pathologic families. Arch Gen Psychiatry 8:68–73, 1963
3. Haley J: Family experiments: a new type of experimentation. Family Process 1:265–293, 1962
4. Bodin A: Conjoint family assessment: an evolving field, in Advances in Psychological Assessment, vol 1. Edited by McReynolds P. Palo Alto, Calif, Science and Behavior Books, 1968, pp 223–243
5. Ravich R: The use of an interpersonal game-test in conjoint marital psychotherapy. Am J Psychother 23:217–229, 1969
6. Reiss D, Sheriff W: A computer-automated procedure for testing some experiences of family membership. Behav Sci 15:431–443, 1970
7. Winter W, Ferreira A, Olsen J: Hostility themes in the family TAT. Journal of Projective Techniques 30:270–274, 1966
8. Howells J, Lickorish J: Family Relations Indicator. Edinburgh, Oliver and Boyd, 1968
9. Elbert S, Rosman B, Minuchin S, et al: A method for the clinical study of family interaction. Am J Orthopsychiatry 34:885–894, 1964
10. Levy J, Epstein N: An application of the Rorschach Test in family investigation. Family Process 3:344–376, 1964
11. Singer M, Wynne L: Differentiating characteristics of parents of childhood schizophrenics, childhood neurotics, and young adult schizophrenics. Am J Psychiatry 120:234–243, 1963
12. Kwiatkowska H: Family art therapy. Family Process 6:37–55, 1967
13. Schulman R, Shoemaker D, Moelis I: Laboratory measurement of parental behavior. J Consult Psychol 26:109–114, 1962
14. Murrell S, Stachowiak J: Consistency, rigidity, and power in the interaction of clinic and non-clinic families. J Abnorm Psychol 72:265–272, 1967
15. Becker J, McArdle J: Non-lexical speech similarities as an index of intrafamilial identification. J Abnorm Psychol 72:408–418, 1967
16. Ferreira A, Winter W: Family interaction and decision-making. Arch Gen Psychiatry 13:214–223, 1965
17. Ferreira A, Winter W: Stability of interactional variables in family decision-making. Arch Gen Psychiatry 14:352–355, 1966
18. Ferreira A, Winter W: Decision-making in normal and abnormal two-child families. Family Process 7:17–36, 1968
19. Sackett A: Alignment patterns in normal and abnormal families. Chicago, Institute for Juvenile Research, 1970 (unpublished study)
20. Hutchinson J: Family interaction patterns and the emotionally disturbed child (abstract), in Research in Family Interaction: Readings and Commentary. Edited by Winter W, Ferreira A. Palo Alto, Calif, Science and Behavior Books, 1969, pp 187–191
21. Schuham A: Power relations in emotionally disturbed and normal family triads. J Abnorm Psychol 75:30–37, 1970
22. Farina A, Holzberg J: Interaction patterns of parents and hospitalized sons diagnosed as schizophrenic or non-schizophrenic. J Abnorm Psychol 73:114–118, 1968
23. Becker J, Iwakami E: Conflict and dominance within families of disturbed children. J Abnorm Psychol 74:330–335, 1970
24. Novak A, Van der Veen F: Family concepts and emotional disturbance in the families of disturbed adolescents with normal siblings. Family Process 9:157–171, 1970
25. Wynne L: Communication disorders and the quest for relatedness in families of schizophrenics. Am J Psychoanal 30:100–114, 1970
26. Levin G: Communicator-communicant approach to family interaction research. Family Process 5:105–116, 1966
27. Haley J: Research on family patterns: an instrument measure. Family Process 3:41–65, 1964
28. Bodin A: Family interaction: a social-clinical study of synthetic, normal, and problem-family triads, in Research in Family Interaction: Readings and Commentary. Edited by Winter W, Ferreira A. Palo Alto, Calif, Science and Behavior Books, 1969, pp 125–127
29. Hetherington E, Stouwie R, Ridberg E: Patterns of family interaction and child-rearing attitudes related to three dimensions of juvenile delinquency. J Abnorm Psychol 78:160–176, 1971
30. Werner M, Stabenau J, Pollin W: Thematic Apperception Test method for the differentiation of families of schizophrenics, delinquents, and normals. J Abnorm Psychol 75:139–145, 1970
31. Goldstein M, Gould E, Alkire A, et al: Interpersonal themes in the Thematic Apperception Test stories of families of disturbed adolescents. J Nerv Ment Dis 150:354–365, 1970
32. Goldstein M, Rodnick E, Judd L, et al: Galvanic skin reactivity among family groups containing disturbed adolescents. J Abnorm Psychol 75:57–67, 1970
33. McPherson S: Communication of intents among parents and their disturbed adolescent child. J Abnorm Psychol 76:98–105, 1970
34. Alkire A, Goldstein M, Rodnick E, et al: Social influence and counter-influence within families of four types of disturbed adolescents. J Abnorm Psychol 77:32–41, 1971
35. Riskin J, Faunce E: Family interaction scales: I, II, and III. Arch Gen Psychiatry 22:504–537, 1970
36. Sines J, Pauker J, Sines L, et al: Identification of clinically relevant dimensions of children's behavior. J Consult Clin Psychol 33:728–734, 1969
37. Riskin J, Faunce E: An evaluative review of family interaction research. Family Process 11:365–455, 1972

Clinical and Theoretical Consequences of the Misuse of Basic Behavior Therapy Concepts

BY DAVID L. BRAFF, M.D.

The basic behavioral terms "aversive stimulation" and "negative reinforcement" are defined and the frequent misuse of these terms in the current literature is illustrated. The author notes the theoretical and clinical consequences of this misapplication, emphasizing the point that unclear thinking about these terms may lead to an unnecessary restriction of the techniques available to the clinician.

THE TERMS "aversive stimulation" and "negative reinforcement" are often misused. This frequent misusage has a number of important consequences. One is to distort the precise, operational meanings of these terms and their theoretical underpinnings. Secondly, the misuse of these terms and the theoretical misunderstandings associated with these errors may lead to restriction of the range of techniques from which a clinician chooses a coherent treatment plan.

First, I will review the precise meanings of the terms "aversive stimulation" and "negative reinforcement." In the operant learning paradigm, an aversive stimulus is an event that follows a response and that decreases the probability that that response will recur. An illustration of this is the case of a child who touches a hot stove and whose subsequent stove-touching behavior is then decreased in frequency. An aversive stimulus is defined in this peripheral manner because the operant paradigm relies solely on response frequencies to determine whether a stimulus is aversive (1, 2).

Negative reinforcement occurs when the probability that a response will recur is increased following the cessation of aversive stimulation. An example of negative reinforcement is the termination of an electric shock after a pigeon pecks at a key in a "Skinner box." The pigeon's subsequent key-pecking behavior thus occurs with greater frequency as a result of negative reinforcement. The principles of negative reinforcement or "anxiety relief" responses (3) have been applied to problems as diverse as homosexuality (4), obsessions (5), and (as noted below) the control of hysterical fits. It should be noted that such techniques are effective in contexts in which the patient agrees that a certain behavior is undesirable.

Dr. Braff is Postdoctoral Fellow and Resident at the Langley Porter Neuropsychiatric Institute, 401 Parnassus Ave., San Francisco, Calif. 94122, and at the Department of Psychiatry, University of California School of Medicine, San Francisco.

MISUSE OF THE TERMS

Many misuses of these terms have appeared in the recent literature. It is important to remember that all reinforcement, be it positive or negative, results in the increased frequency of the response. Positive reinforcement accomplishes this by following a response with a "reward," while negative reinforcement utilizes the cessation of aversive stimulation to achieve the same results. In contrast, aversive stimulation results in the decreased probability that the response will recur. Several examples of the most common misuses of these terms follow.

In their highly regarded *Dictionary of Psychological and Psychoanalytic Terms*, English and English (6) offerred the following erroneous definition of negative reinforcement: "A way of training a subject not to make a response by giving him a dissatisfying or punishing or tension-increasing stimulus" (p. 453). This is clearly the definition of an aversive stimulus and is the most common misuse of the term "negative reinforcement."

In a recent article entitled "Behavior Therapy of Hysterical Fits" (7) the authors stated, "It will be noted that in Phase 1 there were two positive reinforcers for the occurrence of a fit: stopping the electric current and the attention paid by the relative" (p. 604). It is evident from our discussion that stopping the electric current is the cessation of aversive stimulation, which may act as a negative reinforcer. The authors seemed to have lumped all reinforcers together as "positive." This frequent mistake may stem from thinking of "positive" as meaning "more likely to occur." This is the operant definition of all reinforcement, be it "positive" or "negative."

A third example is notable since it appears in *Principles of Behavior Modification* (8) by Albert Bandura, one of the most scholarly of the social learning theorists. He describes how subjects adopt standards of self-reinforcement based on the performance of observed models. Bandura stated, "These findings illustrate how self-esteem, self-concept and related self-evaluative processes can be conceptualized within a social learning framework. From this perspective, a negative self-concept is defined in terms of a high frequency of negative self-reinforcement and, conversely, a favorable self-concept is reflected in a relatively high incidence of positive self-reinforcement" (8, p. 34). In the context of this discussion, a "high frequency of negative self-reinforcement" means that a subject is less likely to reward himself when he has learned stringent standards for self-reinforcement. This actually illustrates a "low" frequency of self-

administered positive reinforcement. There is no negative self-reinforcement illustrated since there is no cessation of aversive stimulation in the experimental design.

DISCUSSION

The main point raised here is the frequency with which some rather elementary terms from learning theory and behavior therapy are being misused in the current literature. This misuse is illustrated without exploring the more sophisticated concepts, such as schedules of reinforcement, spontaneous recovery, and autonomous functioning. Questions raised in this context include the following: Since popular misuse is prevalent, why not accept new meanings for some of these terms or at least accept their misuse? More importantly, what negative consequences stem from this misusage, and does this have any untoward effects in the realm of clinical work?

Behavior therapy is, in a sense, an applied science and as such it utilizes laboratory-tested hypotheses. Although the goals of behavior therapists are often less global than those of their more traditional colleagues, the behavioral approach has the advantage of being highly specific. Much of this specificity of theory and practice is sacrificed when therapists misunderstand basic terms.

More importantly, language has an effect on the therapeutic options available to the therapist. Since some practitioners of behavior therapy equate negative reinforcement and aversive stimulation, they are likely to think of behavior modification along only two dimensions: positive reinforcement to augment behaviors and aversive stimulation to decrease response frequencies. The therapist will then forget that there are many situations in which responses may be reinforced by using aversion-relief therapy, which is the clinical application of negative reinforcement. This would seem to be especially true in the realm of maladaptive approach responses, such as alcoholism and sexual deviations, in which the client gains a subjective "reward" from his symptom. In such circumstances, where techniques of positive reinforcement may not work, a combination of negative reinforcement and aversive techniques may be helpful (9, 10).

To the extent that such basic behavioral terms as "aversive stimulation" and "negative reinforcement" are misused, both theoretical concepts and clinical options may be obscured and distorted. It is recommended that efforts be made to ensure more precision in the theoretical and clinical use of these terms and concepts.

REFERENCES

1. Yates AJ: Behavior Therapy. New York, Wiley, 1970, p 30
2. Solomon RL: Punishment. Am Psychol 19:239–253, 1964
3. Wolpe J, Lazarus AA: Behavior Therapy Techniques. New York, Pergamon Press, 1967, pp 149–151
4. Feldman M, MacColloch M: A systematic approach to the treatment of homosexuality by conditioned aversion: preliminary report. Am J Psychiatry 121:167–171, 1964
5. Thorpe JG, Schmidt E, Brown PT, et al: Aversion-relief therapy: a new method for general application. Behav Res Ther 2:71–82, 1964
6. English HB, English AC: Comprehensive Dictionary of Psychological and Psychoanalytic Terms. New York, David McKay Co, 1958
7. Bhattacharyya DD, Singh R: Behavior therapy of hysterical fits. Am J Psychiatry 128:602–606, 1971
8. Bandura A: Principles of Behavior Modification. New York, Holt, Rinehart and Winston, 1969
9. Blake BG: The application of behavior therapy to the treatment of alcoholism. Behav Res Ther 3:75–85, 1965
10. Clark DF: A note on avoidance conditioning techniques in sexual disorder. Behav Res Ther 3:203–206, 1965

Manifestations of Concentration Camp Effects on the Second Generation

BY HARVEY A. BAROCAS, PH.D., AND CAROL B. BAROCAS, M.S.W.

The authors explore the process by which the concentration camp syndrome, which includes destructive self-identification, is perpetuated in the children of survivors in ways that engender depression, guilt, and aggression and inhibit autonomous growth. They point out the need for further research that will provide a clearer understanding of the dynamics involved and suggest treatment possibilities.

ALTHOUGH IT HAS BEEN LONGER THAN 25 years since the liberation of Nazi concentration camp victims, many of these people are still suffering from the effects of this massive psychic traumatization (1, 2). Despite the growing amount of literature on these survivors, we still know comparatively little about the long-term consequences of this man-made disaster on those who emerged after liberation and even less about the effects of the concentration camp experience on successive generations.

In recent years we have become alarmed at the sizable number of children of concentration camp survivors seeking psychotherapeutic assistance. These children have grown up and are currently coming to the attention of the professional world. Based on clinical experience with such patients our impression is that these individuals present symptomatology and psychiatric features that bear a striking resemblance to the concentration camp survival syndrome described in the international literature (3, 4). This observation, coupled with considerable feedback from many professional groups and from Jewish organizations, clearly suggests a critical need for a clinical follow-up to investigate the psychological development of children of concentration camp survivors.

Although several studies have been conducted on concentration camp survivors since the end of World War II, relatively little has been done to investigate the development of the families formed in the postwar period. One can anticipate that the damage of the concentration camps did not end with cutting the barbed wire or liberating their victims. Documentation of the excesses of cruel treatment to which inmates were subjected provides a basis for assuming that the experience was highly traumatic and that its effects would be likely to persist over time (5, 6).

It is difficult to imagine a person emerging from such a set of experiences without sustaining psychic scars that may become firmly entrenched in his behavioral patterns. The tattooed concentration camp number became the indelible lifelong reminder of the atrocities endured by the survivors. Probably no amount of psychotherapy can ever fully remove the scars inflicted on these people during their incarceration. It is reasonable to hypothesize that the price of survival for these people may have been deep-rooted disturbances within the families they formed after liberation.

Dr. Barocas is Staff Psychologist, Postgraduate Center for Mental Health, 124 East 28th St., New York, N.Y. 10016, and Ms. Barocas is Psychiatric Social Worker, Department of Child Psychiatry, Payne Whitney Psychiatric Clinic, New York, N.Y.

FUNCTIONS OF THE CHILD

The analytic literature suggests that children serve a multitude of functions in the family and may be indirectly rewarded by acting out some unconscious wish of one or both parents. Koenig (7) found that as parents, the concentration camp survivors he studied carried on almost desperate, forced attempts to attain their own identification through their children. Therefore, these parents may use the children as transferential objects, forcing them into a destructive identification.

Destructive identification is associated with the parent's expectation that the child will become an extension of him rather than a separate person and that he will act out that aspect of neurosis the parent most wishes to deny. The parent may further use the child to gratify his own conscious or unconscious needs and consequently inhibit autonomous growth.

He may also force the child to serve a transferential function, to act out roles that appease the parental neurosis by becoming the embodiment of a member of the parent's original family lost in the concentration camp. Although the parents may not resort to overt cruel physical punishment in fostering these roles, this does not mean that the identification will not be destructive or that it has been adopted out of preference in that these children serve a crucial psychodynamic purpose in the family.

Survivors of concentration camps are bottled up with aggressive impulses, and their children may become the transferential recipients of this unconscious and unexpressed rage. The survivors, being terrified of their own aggression and unable to express it, may communicate subtle cues for their children to act out the aggression and thus vicariously gratify the parents' wishes. Reports of aggressive, explosive behavior in these children upon reaching adolescence (1, 4) are thus understandable.

The recent upsurge and interest in Jewish paramilitary organizations may also be a manifestation of this dynamic. On the other hand, the severe depressive reactions

observed in the children of survivors (4) may reflect intense parental and punitive superego restraints culminating in an internalization or somatization of the anger.

From another perspective, the emotional tone communicated by the survivors to their children seems similar to what Lifton (8) called "death anxiety" and "death guilt." Although Lifton wrote about the survivors of Hiroshima, his description is, nonetheless, a very applicable one. The survivor's death anxiety is a realization of how close he came to death as well as a constant awareness of his vulnerability. This anxiety seems to be communicated to the children in the form of a great deal of parental overprotectiveness and exaggerated and paranoid fears in relation to almost any kind of behavior or activity.

Lifton viewed "death guilt" as guilt relating to having survived a holocaust. Questions such as "Why did I survive, while others died?" and "Did I really deserve to live?" are parts of such guilt. It may be this guilt and attempts to explain questions of self-worth that lead the concentration camp survivors to desperately try to attain self-identification through their children. As a result of this vicarious identification, the survivor can probably say to himself, "I am worthy of having lived." It is unlikely that this explanation serves the survivor for very long; sooner or later he is undoubtedly plunged back into a guilt-ridden conflict in an unsuccessful attempt to explain his survival.

To the child of the survivor, death guilt is communicated as an ever-present and unexplained guilt. The child is frequently forced to take on the burden of having to fulfill not only his own developmental needs but also his parent's unrealistic expectations in that he must compensate for the parent's sense of worthlessness.

Minor setbacks and trivial failures may precipitate disproportionate adverse reactions in these children. The family constellation is conducive to exacerbated guilt feelings and severe depressive reactions when confronted with frustrations and failures in their achievements. Failure suggests that the child cannot fulfill the mission of validating his parent's continued existence. Therefore, the parent's unsuccessful attempt to alleviate his guilt through his child's achievements leads the child either to make endless unsatisfying attempts to prove his worth to his parents or to give up and drop out. Although only clinical impressions, these basic dynamics, we suspect, may be feelings and attitudes held among many of the children of concentration camp survivors, either at a conscious or unconscious level.

DISCUSSION

Overall, the process by which the concentration camp syndrome is transmitted and perpetuated in the children of survivors is a highly complex and fascinating one, worthy of considerable clinical exploration. We are currently involved in interviewing concentration camp families to ascertain some of the effects of the parents' experiences on the emotional development of their children. In time, cross-cultural data may be obtained from survivors living in Israel, Scandinavia, Canada, etc. It is hoped that such research will generate a clearer understanding of the dynamics and suggest treatment possibilities for the children of survivors.

REFERENCES

1. Niederland WG: The problem of the survivor. Journal of Hillside Hospital 10:233–247, 1964
2. Eitinger L: Concentration Camp Survivors in Norway and Israel. New York, Humanities Press, 1965
3. Eitinger L: Concentration camp survivors in the postwar world. Am J Orthopsychiatry 32:367–375, 1962
4. Rakoff V, Sigal JJ, Epstein NB: Children and families of concentration camp survivors. Canada's Mental Health 14:14–16, 1966
5. Bettelheim B: Individual and mass behavior in extreme situations. J Abnorm Soc Psychol 38:417–452, 1943
6. Frankl V: The Doctor and the Soul: An Introduction to Logotherapy. New York, Alfred A Knopf, 1955
7. Koenig W: Chronic or persisting identity diffusion. Am J Psychiatry 120:1081–1084, 1964
8. Lifton RJ: Psychological effects of the atomic bomb in Hiroshima—the theme of death. Daedalus 92(3):172–197, 1967

IN MEMORIAM

Eugen Kahn
1887–1973

Dr. Eugen Kahn, Emeritus Professor of Psychiatry at Baylor College of Medicine and former Sterling Professor of Psychiatry and Mental Hygiene at Yale University, died in Houston, Tex., on January 19, 1973, at the age of 85.

Dr. Kahn was born in Stuttgart, Germany, on May 20, 1887. He was educated at Heidelberg, Berlin, and then at Munich, receiving his M.D. in 1911. He spent the next 18 years in Munich as an assistant and associate on the staff of the Psychiatric Clinic, in close association with Dr. Emil Kraepelin.

In 1930 Dr. Kahn went to Yale, where he served not only as Sterling Professor of Psychiatry and Mental Hygiene but also as Chairman of the Department of Psychiatry until 1946. He also served as Psychiatrist-in-Chief of the New Haven Hospital.

Dr. Kahn then moved to Switzerland, where he remained until 1951. In that year he returned to America, coming to Houston to join his former associate at Yale, Dr. Warren Brown, then Chairman of the Department of Psychiatry at Baylor. Dr. Kahn remained on the full-time staff of the Department of Psychiatry as a Professor until 1962; for one of these years he also served as Acting Chairman of the Department. After 1962 he was Professor Emeritus at Baylor.

During his 22 years in Houston, Dr. Kahn was also a research associate in psychiatry at the Houston State Psychiatric Institute (Texas Research Institute of Mental Sciences) and a consultant in psychiatry at the Veterans Administration Hospital.

Dr. Kahn's entire career was spent in teaching, research, and scholarly activities. He read and wrote constantly on a very broad range of topics. There is no exact count of his publications, but he published at least 120 papers, hundreds of book reviews, and four books, the best known of which is *Psychopathic Personalities*, published in 1931. His most recent book, *The Past Is Not Past*, was published in 1962.

During his Munich years, Dr. Kahn was much influenced by Kraepelin, who remained a dominant influence in his thinking. During this period Dr. Kahn wrote papers proposing the classification of patients with schizophrenic features into: 1) genuine schizophrenias, 2) schizoid reaction types (a partial expression of schizophrenic anlage or genetic tendencies), and 3) schizoform reaction types (exogenous); this classification is reminiscent of the recent ideas about schizophrenic spectrum disease. His concept of psychopathic personalities also included the notion of incompletely developed or expressed psychoses; furthermore, what we think of as neuroses were included under psychopathic personalities.

During his years at Yale Dr. Kahn taught many of the present leaders in American psychiatry. He pioneered in many areas; for example, he was the chairman of the executive committee of the Committee for the Study of Sex Variants, Inc., formed in 1935. In 1934 he and Louis Cohen published their classic paper on "organic drivenness," a precursor to subsequent work on minimal brain damage, hyperactivity, and impulsivity.

Those of us who were privileged to know Dr. Kahn during the third phase of his career, his 22 years in Houston, knew him as a vigorous, restless, courtly gentleman who enjoyed arguments and loved stories. He read voraciously and yet always seemed to be writing, corresponding, lecturing, and visiting with students, residents, nurses, chaplains, and other colleagues. He had strong likes and dislikes, which he hid poorly. In his lecturing and teaching he characteristically used vigorous gestures and facial expressions. One of his favorite teaching sessions was a formal lecture given every other week to a regular circle of students of all ages and disciplines. Dr. Kahn would prepare each lecture with loving care and superb scholarship, and many were later published. One cannot help recalling Dr. Kahn's statement about Kraepelin's lectures: "These clinics for which the professor prepared himself scrupulously were classics." Dr. Kahn's lecture topics were extremely diverse: schizophrenia, historical figures in psychiatry, figures from European and American history, Jesus, Dali, Mary Baker Eddy, suicide, aspects of psychiatric diagnosis, Kierkegaard, Picasso, etc. For several years he was deeply involved with phenomenology and existentialism, about which he spoke and wrote widely. He resisted being stereotyped and did not even want to be thought of as a Kraepelinian.

Dr. Kahn contributed many articles and book reviews to this journal, including an October 1956 paper on the 100th anniversary of Kraepelin's birth. During the past two decades he wrote many such commemorative pieces, most of them published in Europe.

He was physically vigorous and resilient. During his last few years he successfully overcame cancer, endocarditis, and several lesser ailments. He continued to live at home with his wife, Marianne, until two days before he succumbed to congestive heart failure.

Eugen Kahn will be remembered for his personal accomplishments, his published writings, and for the continuing achievements of his many former students. In his honor, the Eugen Kahn Award was established several years ago at Baylor; it is given each year to the outstanding resident in psychiatry.

Recently the board room at the Texas Research Institute of Mental Sciences was renamed the Eugen Kahn Room; it will contain many of the books he treasured and enjoyed, including his dog-eared four-volume personal copy of Kraepelin's textbook, the most valued literary possession of a man who devoted much of his life to reading and writing medical literature.

ALEX D. POKORNY, M.D.

LETTERS TO THE EDITOR

The Funding Crisis: An Opportunity for Growth

SIR: Recent and proposed budget cuts make it apparent that NIMH will not be a continuing source of funding for psychiatric education. The psychiatric community, as represented by APA and various groups of educators, is responding to this crisis only in terms of its financial aspects. They are fighting to maintain current levels of funding, arguing that the only alternative is a serious loss of functioning in psychiatric education. We propose that funding and education are related but separate issues and that the funding crisis represents a unique opportunity for growth in the field of psychiatric education.

Psychiatric education has developed relatively unhampered over the past 25 years. While there has been much initiative and creativity, there are no practical or enforceable standards that educators or graduates are required to meet. There is no effective means of measuring either the quality of the programs or of the psychiatrists they produce. Until now there has been no need to do so. There was enough money to go around, so we measured effectiveness in terms of the quantity rather than the quality of the graduates.

The current response to the fiscal cuts is directed only to the quantity crisis. There are those who argue that everyone should be cut by an equal percentage without regard for the quality or priority of the programs and graduates. Others argue that those programs most dependent on NIMH should be cut more slowly—again a matter of the quantity of money rather than of the quality of the program and graduates.

We see the fiscal crisis as a long-needed opportunity for psychiatric education to reevaluate itself. Before effective and stable alternative funding can be developed, psychiatry needs to ask itself: How many and what kinds of psychiatrists do we need? How should they be educated? What kinds of standards can we develop for training programs and their graduates? How can we effectively measure and enforce the standards? By an actual cost accounting study, how much income does a resident generate in a program where these standards are met, and what is the actual cost of the resident's education as separate from the other educational responsibilities of a department? What is a reasonable cost-efficiency ratio in terms of dollars per resident?

If we don't answer these questions before developing new funding sources, the residents' education will be secondary to the dictates of the program's source of money. They will spend more time on inpatient services or in special programs, such as drug and alcohol abuse, because of the income generated rather than the educational opportunities provided. Programs most adept at raising money will produce the most psychiatrists. There will be no effective measure of or control for the quality of graduates, and we will continue to be mired in the concern for quantity.

Some will argue that these questions cannot be answered or that they cannot be answered now. We submit that they must be answered. If we cannot define how many psychiatrists we need to educate, demonstrate a reasonably comparable cost of educating them in approved programs, and assure the effective quality control of both programs and their graduates, then we do not deserve any money. If we do answer these questions, psychiatry will be in the forefront of professional educational practices, and funding will be a solvable problem.

JOHN M. SCANLAN, M.D.
Chairman, Task Force of Residents
THOMAS RODGERS, M.D.
IDA M. HILLIARD, M.D.
WESLEY B. CARTER, M.D.
THAD H. BILLINGSLEY, M.D.
TIAH FOSTER, M.D.
ALAN A. AXELSON, M.D.

Voluntary Faculty in Psychiatric Education

SIR: The feeling I and most of my colleagues share is that the best contributions to our residency training came from voluntary faculty members. In view of the trend in many centers toward purely full-time faculty, I would like to present briefly some of the reasons for recommending a reversal of this trend and to encourage the use of voluntary faculty members, whom I define as people in full-time private practice who contribute about two to four hours per week without pay to lecturing, conducting seminars, or supervising psychotherapy.

Most voluntary faculty teach because they *want* to, not because they *have* to, as is the case with full-time faculty. Because faculty members who are volunteers reduce their potential income quite substantially, a less able volunteer teacher can be retired with fewer hurt feelings, which may be compensated by other work at greater income, while a full-time appointee who is a poor teacher may have to continue to teach for administrative reasons.

As residents, it often seemed to us that full-time faculty adhered to a somewhat narrower "party line" approach, perhaps related to their remaining closely attached to or dependent on an institution; while volunteer faculty members, who are under little or no obligation to follow institution "policy" (which is often unwritten), could take a more neutral and impartial view, offer different ways of seeing patients in terms of assessment and management, and help broaden residents' outlooks and attitudes.

There are many different ideas as to how residents learn to become psychiatrists, but certainly in a field where personality is so much more important than precise factual knowledge of, for example, blood values, the role model is of considerable significance.

As residents, we noted that there were established therapists on the volunteer faculty whose warmth and charm enabled patients to relax immediately, while many full-time staff members had so many different things to do in a day (administrative work, committee meetings, clinical work, teaching, etc.) that it was difficult for them to feel relaxed with patients. Consequently they often presented a poorer role model.

In terms of psychotherapy the volunteer faculty therapist is doing therapy constantly, usually has had his own analysis, and has made more of a commitment to therapy than full-time fac-

ulty members have. In this respect the volunteer again serves as a more positive role model.

When considering the three main types of teaching—lectures, seminars, and supervision of clinical work—it might be thought that, particularly in a university department, lectures and seminars given by the full-time staff would be more up-to-date and sophisticated. However, particularly in psychiatry, relatively little has emerged from research that is currently of practical relevance to clinical work; therefore, for the vast majority of residents who will be working with human beings, the volunteer staff members who have had to integrate their theoretical knowledge on a practical level also have a significant contribution to make.

Perhaps the most crucial point of all is supervision, for whether one believes that psychotherapy is the essence of psychiatry, as I do, or views psychotherapy as but one of many approaches to the troubled patient, most psychiatrists, I think, agree about the importance of good supervision.

Any form of dynamic therapy must deal with what the therapist has done and with the possibilities of countertransference. For some worthwhile communication and understanding of the resident's own feelings and actions to take place, the resident must feel free to express himself. This freedom cannot fully exist in a situation in which the supervisor is also a part of the administration that has a direct say in the resident's progress and possible future career. Volunteer faculty who see their job as supervising and teaching, rather than as sending reports on their residents, are in a better position to accomplish adequate supervision.

There are, of course, some deficiencies in volunteer faculty. For some people it is a matter of hanging around for a few hours because of dependency needs, for others a means of obtaining admitting privileges while contributing the barest minimum. Some people in practice have strong feelings about teaching institutions and may subtly encourage their residents to rebel so that they can experience the rebellion vicariously, to the detriment of the residents.

However, our overall impression is that the volunteer faculty have a very important place in psychiatric education, and their contribution should be welcomed and encouraged.

JOSEPH BERGER, M.D.
Downsview, Ont., Canada

Adolf Meyer and Psychobiology

SIR: In your Special Section on Psychobiology (January 1973 issue) I was astonished to find that the contributors did not make the important distinction between psychobiology and biological psychiatry, although I do appreciate the opinion expressed by Dr. John Davis on "Biological Psychiatry" in his editorial.

Since I was a student of Dr. Adolf Meyer and had the privilege to serve under him as House Officer at the Phipps Clinic before he retired in 1941, I hope I may speak on the subject of psychobiology with some authenticity.

According to what I learned, psychobiology is a science of man with all-encompassing perspectives, ranging from physics and chemistry on the one end to sociology, anthropology, and philosophy on the other, but with the middle section or main body being the study of personality in all its functions hanging together around the concept of integration.

In the Special Section, though learned and scholarly the authors may be, all six articles expounded the use of drugs with mental illnesses or certain aspects of the biochemistry of mental illnesses without resorting to an extensive or intensive study of personality factors related to these conditions.

In the realm of psychobiology, some psychobiologists have joined the ranks of leading psychoanalysts, while still giving tribute to Adolf Meyer as the one who gave them the impetus and who laid the foundation for psychodynamic psychiatry. Many former students of Meyer have entered a great variety of medical specialties and scientific careers and all have continued to pay tribute to him for having given them the inspiration to enter their respective fields. On the basis of my personal associations at Phipps, the following is only a partial list of those who bear the earmarks of a basic psychobiologic foundation in their training:

Theodore Lidz, Professor of Psychiatry, Yale University (psychoanalysis, family process of schizophrenics), who presented, in my opinion, an excellent Adolf Meyer Lecture at the 1966 APA annual meeting; Victor H. Rosen, former President of the American Psychoanalytic Association; Jerome D. Frank, Professor of Psychiatry, Johns Hopkins University; Alexander H. Leighton, former Professor of Anthropology and Sociology, Cornell University, and currently Professor of Behavioral Sciences, Harvard University; Hilde Bruch, Professor of Psychiatry, Baylor University (psychosomatics); and Paul Lemkau, Professor of Public Health, Johns Hopkins University.

I wonder whether, in a future issue of the *Journal*, another section on psychobiology could be contemplated with some of these APA members participating. If so, this may be the kind of special section on psychobiology more to the late Dr. Adolf Meyer's liking.

RICHARD P. WANG, M.D.
Princeton, N.J.

The Need for Feedback to Authors

SIR: I am taking this opportunity to comment on the lack of adequate feedback given to authors of submitted manuscripts. It is my contention that every manuscript deserves close attention by and written feedback from expert reviewers, whether the paper is accepted or found unsuitable. In particular, these comments are directed at certain journal editors—although certainly not personally at the Editor of this journal—and at the APA Program Committee.

It is commonplace to have editors return manuscripts with a brief note containing the decision about acceptance or rejection but with little additional information. A lack of adequate feedback to authors is reprehensible, for even a paper of the highest quality can be improved substantially as a result of suggestions by an informed reviewer. The need is even greater for accepted than for rejected manuscripts since it is the readership, in addition to the authors, who may be shortchanged.

It is common knowledge that editors and their reviewers are exceptionally busy and donate their time to editorial duties without adequate compensation. Nevertheless, I submit that feedback to authors should have the highest priority. I see no good reason why editors could not increase their pool of reviewers in the event that their regular consultants become overextended.

The situation is similar for papers submitted to the Program Committee for presentation at the APA annual meeting. Only a form letter is sent to the authors. Admittedly, the members of the committee have a gigantic task when judging the merit of approximately 1,000 papers, and they can hardly be expected to read each one, let alone to write reviews. Nevertheless, since

the total membership is invited to submit manuscripts for the meeting, APA in turn ought to assume the obligation to return brief critiques to the authors of each paper, whether or not it has been accepted. In order to accomplish this task the Program Committee would have to be greatly expanded and/or broken up into sections. I feel such a change would be feasible given the resources of the organization.

GEORGE GARDOS, M.D.
Boston, Mass.

Editor's Note: Rejected manuscripts *usually* are accompanied by a note giving the reasons why. However, sometimes when the reviewer's remarks are abrasive, feelings of the rejectee are spared. When a manuscript is accepted, that in itself spells some form of approval even though the editorial staff often has to do further work on it.

As to the editor's arrogating to himself the role of the oracle at Delphi and teaching authors—that's out. The troops wouldn't stand for it. His job is thumbs up or down—for cause.

F.J.B.

Behavioral-Gluco-Dysrhythmic Triad

SIR: It has been reported that in nonepileptic psychotic patients with symptoms of violence, impulsiveness, destructiveness, and/or aggressive behavior, a definite improvement was observed after the administration of diphenylhydantoin (DPH) (1–5), with the exception of one negative report (6).

In our study, from a sample of 20 violent psychotic patients ten presented abnormal EEG tracings, indicating brain dysrhythmia. Nine of these patients had shown a functional hypoglycemic curve after a six-hour oral glucose tolerance test (six-hour GTT) and diphenylhydantoin (DPH) therapy and/or the use of neuroleptic agents failed to control the behavioral symptoms. In these cases instituting a low carbohydrate diet corrected that symptomatology. It is not uncommon to see hypoglycemia associated with violent behavior, psychiatric symptoms, or convulsions. The same could be said of brain dysrhythmia. However, if the triad was present, the prescription of DPH or the diet was ineffective in controlling violent behavior unless both were prescribed together. This therapeutic response would indicate that the presence of violent behavior, brain dysrhythmia, and hypoglycemia constitutes a new triad.

In reviewing the literature we have failed to obtain any previous reports similar to ours. In the meantime we treat our patients as follows: 1) diphenylhydantoin (90 to 300 mg. daily), 2) hypoglycemic diet, and 3) pyridoxine (400 to 1000 mg. daily). The urge to report these findings is due to the renaissance of psychosurgery for clinically untreatable cases of violent behavior. It is suggested that in those cases a six-hour GTT be done before electing psychosurgery as the treatment of choice.

For the time being, we continue to investigate the significance of this syndrome, and more detailed data will be presented at the completion of the ongoing research.

REFERENCES

1. Diamond B, Yaryura-Tobías JA: El uso de la difenilhidantoina en una población psiquiátrica no epiléptica, in Abstracts of the Fifth World Congress of Psychiatry, Mexico, Nov 28–Dec 4, 1971. Edited by the World Association of Psychiatry. Mexico, DF, La Prensa-Medica-Mexicana, 1971, p 265
2. Kalinowsky LB, Putnam TJ: Attempts at treatment of schizophrenia and other nonepileptic psychoses with Dilantin. Arch Neurol Psychiatry 49:414–420, 1943
3. Freyhan FA: Effectiveness of diphenylhydantoin in management of nonepileptic psychomotor excitement states. Arch Neurol Psychiatry 53:370–374, 1945
4. Kubanek JL, Rowell RC: The use of Dilantin in the treatment of 28 psychotic patients unresponsive to other treatment. Dis Nerv Syst 7:1–4, 1946
5. Turner WJ: Anticonvulsive agents in the treatment of aggression, in Proceedings of the Symposium on the Biology of Aggressive Behaviour, Milan, May 16–19, 1968. Edited by Garattini S, Sigg EB. Amsterdam, Excerpta Medica Foundation, 1969, pp 353–362
6. Klein DF, Greenberg IM: Behavioral effects of diphenylhydantoin in severe psychiatric disorders. Am J Psychiatry 124:847–849, 1967

J. A. YARYURA-TOBÍAS, M.D.
Buenos Aires, Argentina

Activist and Traditionalist Approaches in Psychiatry

SIR: I found the article "Current Strains for Mental Health Trainees" by Drs. Brenneis and Laub (January 1973 issue) to contain many accurate, insightful descriptions of activist and traditionalist attitudes within psychiatry. But I regret that the authors, having drawn the distinctions and having identified themselves as reflective therapists, felt satisfied in limiting themselves to a plea for peaceful coexistence between the two camps. Although their concluding wish to end the necessity among trainees of "choosing sides" is valid enough, this conclusion itself completely shortchanges the entire activist position, which they initially delineate so well but in the end substantially ignore.

The activists maintain, in essence, that such peaceful coexistence is wrong—that is, immoral—since it allows for the continued training of traditional psychotherapists, whom they perceive as performing self-deceptive, wasteful, elitist, and socially useless work. For the authors to recognize this perception and then to disregard the inevitable necessity of answering it by simply pleading for coexistence, demonstrates, in my view, a selective inattention to that part of the activist position which is at the root of what appears to be the recent devaluation of traditional therapies.

I think this inattention is possible because it grows out of a tendency that flourishes in psychiatric literature. It seems inevitable that psychiatrists pay more attention to the form of an argument than to its content. This makes sense in certain clinical situations but constitutes an occupationally induced hazard in psychiatric communication. Drs. Brenneis and Laub are able to subtly sidestep the issue of dealing with the substance of the activists' "totalistic" argument by describing them as mental health workers who have been unable to overcome the narcissistic wounds they have sustained in not realizing their fantasies of psychotherapeutic omnipotence and who have therefore turned to other areas, specifically activism. Despite its objective, clinical garb, this analysis constitutes a classically ad hominem position that is, when used as a mode of argument, always unfair. Moreover, it is absolutely futile in discourse between psychiatric camps, since each side is professionally expert in the method, and it becomes, in the end, the least likely royal road to any form of coexistence.

WALTER REICH, M.D.
New Haven, Conn.

Drs. Brenneis and Laub Reply

SIR: We appreciate Dr. Reich's thoughtful response to our

paper and shall attempt to deal with the two major issues he raises.

To Dr. Reich's concern that we have bypassed the activists' claim that the work of traditional psychotherapy is "self-deceptive, wasteful, elitist, and socially useless," we would like to respond that this claim, however vigorously made, has the quality of a political proclamation. Cogent data are not offered because what is sought is ideological adherence. We are tempted to respond with a parallel counterclaim that is similarly ideological in nature. That is, as we stated, our vantage point suggests that experience with and exposure to individual distress is a necessary precondition for an informed, competent approach to the kinds of distress evident in groups, be they ethnic, cultural, economic, or geographical. The human experience begins with a dyad—the mother-child unit—out of which more differentiated, complex, and wider-ranging relationships develop. Experience with this crucial aspect of human development, to our minds, should form a core from which the training of any mental health worker may expand and ramify.

But to respond with an ideological counterproclamation would indeed miss our own point. Our effort was to suggest a shift in the argument away from an ideological battlefield of what is right or wrong with all the pitfalls this poses. A less charged, more detached arena is necessary to ensure that no assumption is exempt from being tested and no method is exempt from being tried out on the grounds of inherent "rightness" or political goodness. The emphasis on peaceful coexistence is, therefore, not a plea for the right to coexist but reflects our intent to resolve the argument through a method that values data more highly than value statements and ideologies.

We feel that Dr. Reich's second concern that our argument constitutes a classically ad hominem position, which is to discredit the other side's ideas by discrediting their motives, is simply unfounded. Our basic disagreement is not with the ideas proposed by the activists but with the arbitrary limitations imposed on testing the methods by which these ideas are pursued. Such humanist ideals—to help and to cure the mentally ill patient or society—are usually pursued with a great deal of fervor, dedication, and self-absorption, hence the dangers of "wounded narcissism" when obstacles are met and failure is experienced. The often blinding side effects of such wounded narcissism are therefore an occupational hazard to reflective as well as to activist mental health workers.

Our contention is that a politically permeated approach foregoes its chances to deal with and dampen the untoward effects of wounded narcissism because of the ideologically motivated and justified abandonment of adequate methods of self-correction through introspection and self-scrutiny. It is as though continuing to see the emperor's new clothes were elevated from an unfortunate deception due to conformism, group pressure, and self-protection to an act of utmost morality.

C. BROOKS BRENNEIS, PH.D.
DORI LAUB, M.D.
New Haven, Conn.

BOOK REVIEWS

In the Name of Life: Essays in Honor of Erich Fromm, *edited by Bernard Landis and Edward S. Tauber. New York, Holt, Rinehart and Winston, 1971, 333 pp., $10.95.*

It is right that Erich Fromm be honored in his lifetime, and these essays do him honor. Fromm deserves far more recognition among psychiatrists and psychoanalysts than he has thus far received. More than anyone before him, he sought to systematically revise psychoanalytic theory so as to make it congruent with social, cultural, and political reality. Perhaps this volume will help others to appreciate the relevance and significance of this effort.

One comes away from this series of brief encounters with lively and scholarly minds (24 in all, arranged in three groupings—psychoanalysis, philosophy and science, and social and political issues) with a sense of what is occurring at the advancing edge of man's knowledge about himself as an individual and as a social creature, vulnerable to both psychological and social stresses and subject to a burdensome as well as helpful cultural inheritance. Add to his woes those of the miscarriage and misdirection of political aims, and the almost desperate concern for man's fate expressed by many of the essayists becomes understandable.

Isaac Asimov, in particular, captures with a few startling figures the plight in which our immediate progenitors are apt to find themselves. Others arrive at the same point of concern via different routes. Edward I. Hall's essay on some of the latent as well as manifest cultural traps is a gem in this respect. The psychoanalytic concerns rooted in more microcosmic contexts are perhaps the most optimistic. Included are contributions by Will, Guntrip, Erwin Singer, Searles, and Schechter. The several Yugoslav Marxist scholars present a balanced and informative discussion of some of the problems of Marxism assessed from the vantage point of history. The essays on "The Possibilities for Radical Humanism" (by Markovic) and "Humanism and Revolution" (by Petrovic) are particularly enlightening.

Fromm in his writings touches on almost every aspect of man's plight, and the diversity among the contributors reflects this fact. The absence of any orienting statements on the part of the editors other than an introductory chapter makes for some disconnectedness in the impact on the reader, who is also left to wonder how some of the contributions link up with Fromm's thought other than at the most general and abstract level of a concern with humanistic values and man's future in the face of the obstacles that beset his path. In fact, most of the essays contain no mention of Fromm.

Its richness as well as diversity makes this a valuable and satisfactory volume. It also suggests that perhaps another kind of volume should follow it, namely, one that attempts to come to grips with the specific and original elements of Fromm's thought from the point of view of the many disciplines into which they have penetrated. The current scene in the social sciences could profit by the more systematic and widespread application of such concepts as the social unconscious, the economic underpinnings of character structure, the role of character versus instinct in man's development, and, finally, some of Fromm's projections of the prerequisites for a sane society.

MONTAGUE ULLMAN, M.D.
Brooklyn, N.Y.

Children and Mental Health Centers: Programs, Problems, Prospects, *by Raymond M. Glasscote, M.A., Michael E. Fishman, M.D., and Meyer Sonis, M.D. Washington, D.C., Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1972, 257 pp., $6.*

Ambiguity and confusion have beset the issue of services for children within the community mental health center programs from the time federal funds were made available for planning in 1963. This latest field study of the Joint Information Service places the subject in perspective by reviewing the history of child mental health care, the various reports of children's needs in the United States, and the vicissitudes of programming for children during the last decade of developing community centers.

The report then describes field studies of eight programs serving children and adolescents that were selected for their diversity in terms of component parts, demography, socioeconomic characteristics, ethnicity, auspices, and section of the country. They were chosen from a brief survey of the 206 federally assisted community mental health centers, which in itself elicited provocative information. Of the 70 percent responding, 63 percent indicated that they provided all five essential services for children and 79 percent for adolescents. Partial hospitalization and inpatient services for children were most significantly missing. Adolescents appeared to be served quite well, but children under age four, very little. In general, the responses indicate that the only service in which children and adolescents are served to a greater degree than their proportion of the general population is consultation and education and that in all others they are considerably underserved, while adolescents as a proportion of the total patient load are considerably better served than children in all respects.

The staffing patterns reported are of great interest in considering the nature of the children's programs within the community mental health centers. For instance, 56 percent of the respondents did not indicate a child psychiatrist on the staff, 53 percent did not indicate any kind of physician in the service for children and adolescents, 80 percent did not indicate any teachers, and 65 percent, any nurses. All but 14 percent indicated at least one psychologist, and all but 16 percent indicated at least one social worker. The survey does show progress in providing children's services over the situation reported in 1967, 1965, 1963, and earlier. However, four characteristics of most of the children's centers studied by questionnaire and in depth require careful consideration. It is difficult to determine how much a certain programmatic feature or omission evolved from a philosophical and professional commitment or where the nature of a staff reflects recruitment realities or preferences of the leadership until one has spent a great deal of time delving into his-

tory and talking to many about current practices. A questionnaire, of course, gives one little information about such factors.

What is immediately striking about the survey's findings is that the treatment modality given first place is crisis intervention. The evidence is not yet in—and this is an area urgently needing evaluative research—about the effects of crisis intervention upon the growth and development of children. Environmental manipulations and guidance can very often change the symptomatic picture that brought a child to a program; but what happens to children later is a concern coming up repeatedly as children return time and again with other crises. Undoubtedly such services, which are far more than many of these communities had available for children previously, represent significant advances in child care. But one is uneasy that a virtue is being created out of a necessity: Crisis intervention may be the only modality available, and it can then come to be accepted as the most desirable and adequate approach.

There are few programs of drug therapy mentioned and indeed little mention of involvement with health services in general. Child psychiatrists, pediatricians, and neurologists are absent from staff rosters in over half of the 206 centers surveyed. Such characteristics of so many centers may well reflect the turning away from what is termed the medical model. Indeed, the preferences for sociological approaches, for social rather than psychological techniques, may mean that embracing the view that society, rather than the individual or child, is ill and disordered has carried with it deficits in therapeutic and assessment modalities in many community mental health centers. This can prove unfortunate. Physical and mental health are difficult to separate out in children; furthermore, developmental and neurological dysfunctions make up a significant group of the problems that bring children to a mental health service.

Related to this general consideration is the very limited activity reported with infants and children three years old and younger. Prevention and early intervention during the child's first three years probably represent our most powerful tools to influence growth and progressive development and so contribute directly to mental health. These activities, however, require collaboration with physicians and nurses and joint activities in hospitals and clinics.

It was surprising, too, to read little of psycho-education programs in these reports and to learn that few educators were on the staffs of the surveyed centers.

Controversies abound in the field of childhood emotional and mental illness. The central question seems to be: How can we do our best to ensure that what we do promotes the child's growth and stimulates his progressive development? This book does us all a real service. If we can all evaluate what we are doing, exchange experiences, and reach for flexibility of action within a framework of sound assessment and knowing disposition, we should be able to make headway in the task large, indeed, of seeking "to be responsible for the mental health of all the children in our catchment area."

EVEOLEEN N. REXFORD, M.D.
Boston, Mass.

Focal Psychotherapy: An Example of Applied Psychoanalysis, *by Michael Balint, Paul H. Ornstein, and Enid Balint. Philadelphia, J.B. Lippincott Co., 1972, 161 pp., $10.*

The greatest portion of this book is devoted to the session-by-session account of "focal psychotherapy" conducted by the late Dr. Michael Balint with a patient suffering from a paranoid jealousy. In their use of the term "focal psychotherapy" the authors agree with T.M. French that this technique for shortening classical psychoanalysis is brought about by the method of consistently and persistently attempting to interpret focal conflict. Focal conflict is one that is preconscious, closest to the surface at any one time, and serves to explain most of the clinical material of a given therapeutic session. The schematic structure of a focal conflict is as follows: A "disturbing motive" (an impulse or a wish) is in conflict with a "reactive motive" (a superego or ego response), creating the necessity for finding a "solution" (an adaptive or defensive compromise). No direct attention is paid to what are called "nuclear conflicts," which presumably originate during crucial developmental periods in early life.

In the introduction Paul H. Ornstein states that the authors' chief aim was to study the interaction between patient and therapist and that their concern with the proof that focal therapy leads to acceptable therapeutic results was only secondary. The patient was treated exclusively by Michael Balint; he was seen for 27 sessions over a period of approximately 15 months. Following this he was followed directly for four and one-half years, during which time he was seen directly for follow-up and recheck only two or three more times. Dr. Balint was also kept informed of the patient's progress by letters from the patient's general practitioner and from the patient himself.

This particular book does not seem to be as innovative a representative of brief psychotherapeutic technique as perhaps the authors would wish to exemplify. However, this may be due to the facts that the authors have previously mentioned their technique in other papers and that the reader's memory also calls upon the work of Alexander and of French.

The methodology of research reviewed in this book takes place within the limits of the focal therapy workshop established by the psychoanalytically trained staff members of the Tavistock Clinic and the Cassel Hospital. In his work with the patient reported in this book, Michael Balint met with the focal therapy workshop once a week for a period of two hours. Previously agreed-upon forms had been filled in following each therapy session. Each session was reported in a formal manner and included such headings as Initial Expectations, Atmosphere in the Interview with Changes if Any, Main Trends of Therapeutic Interventions Given, Therapeutic Interventions Thought of But Not Given, Therapist's Focal Aims in the Interview, The Outcome of the Interview, and finally, After-thoughts. The reporting of the case in the book under consideration follows this format for each interview.

The patient whose psychotherapy is detailed, a 43-year-old company director, was referred for treatment with Dr. Balint by his general practitioner. The patient complained of an obsessional preoccupation with the fact that his wife had had a brief love affair with another man before her marriage. The patient's preoccupation with this situation took the form of an extreme paranoid jealousy that evinced itself in his repetitive cross-examination of his wife regarding the most minute details of what had happened between her and the other man.

It would be impossible in a review of this length to even summarize the therapy, since the therapeutic sessions themselves are reported in condensed form. The authors' intention to study the interaction between patient and therapist has been well realized. The chief value of the book is to show the interaction between a very disturbed and sick patient and a wise, experienced, and empathic therapist. The account of the case hour by hour, and particularly Dr. Balint's internal decisions as to what interpretations he should make openly and those which he thought of but did not give, is very instructive. There is a refreshing lack of omniscience and omnipotence in the therapist's review of each hour, particularly under the headings labeled "Afterthoughts." Balint purposely and honestly reveals himself to be

frequently as bewildered and indecisive as the rest of us mortals who find ourselves devoting a great deal of our time to individual, analytically oriented psychotherapy.

This will be a very reassuring book to any psychotherapist, either experienced or novice. Moreover, it reveals to us the essential warmth and kindness of the late Dr. Balint as well as his therapeutic skill and his constant primary concern for the welfare of the patient. In spite of its slender size and rather high price, the book is strongly recommended.

MAURICE J. BARRY, JR., M.D.
Rochester, Minn.

Clinical Supervision of the Psychiatric Resident, *by Daniel B. Schuster, M.D., John J. Sandt, M.D., and Otto F. Thaler, M.D. New York, Brunner/Mazel, 1972, 328 pp., $10.*

The authors of this book, which represents a fine effort to update all that is known about clinical supervision of the psychiatric resident, close with this sentence: "We can—we must—learn from each other." They abide by their own exhortation.

The authors freely share their own experiences in their particular clinical setting, describing the training program with all of its assets and defects. The last section, which comprises more than half of the book, is a printed recording of the supervisory conference of their staff as they discuss problems that arise in the course of supervising individual residents. This section is valuable for those readers who may be in the early stages of learning about the supervisory process, but it is somewhat tedious reading for the more experienced clinician.

The more interesting and worthwhile contributions are contained in the first half of the book, where the authors state their biases, convictions, and concerns about psychiatric residency training programs; where they review the entire literature on this subject; and where they address themselves to basic issues, make proposals, and recommend solutions.

Their bias, clearly stated, is that for the young psychiatrist in training, learning to become an expert clinician occurs primarily by means of a careful study of individual patients and the repeated experience of being a participant in the changes that occur in one's own patients over extended periods of time (long-term, one-to-one psychotherapy).

The authors are convinced that the resident must learn to make observations and derive data from patients before he can understand concepts of human behavior or construct his own theories about human motives. Another important aspect of the resident's development and maturation is the day-to-day living with physical disease, pain, suffering, decay and death, anxiety, guilt, and shame. This kind of experience, an integral part of medical education, coupled with graduated responsibility for the lives and destiny of patients, powerfully shapes the attitudes of the clinician. The authors further state that of all the instruction offered residents, including thoughtfully developed seminars, lectures, readings, and clinical conferences, the exercise most prized is the resident's regular tutorial or supervisory session—his own individual time spent with his mentor, unshared with his "psychiatric siblings" or peers.

The concerns expressed by the authors have to do with the impact of recent radical changes in the sociopolitical psychiatric scene. The authors are concerned first and foremost with the survival of the clinician in view of the many changes being imposed upon medical education systems. Such changes are the elimination of the internship requirement for a residency, the identity crisis of the psychiatrist and psychiatry, the overburdening of core curricula with a variety of courses and seminars on the newly emerging therapeutic fads, and community pressures for delivery of services, to mention a few.

The review of the classic and recent literature on the philosophy, goals and purposes, methodology, techniques, problems, and issues of clinical supervision is replete and excellently presented. This section alone justifies the addition of this volume to the existing literature in the field. The role and function of the supervisor and supervisee and all the nuances of their relationships are adequately described and dealt with.

The chapter on "The Ontogeny of the Psychiatric Physician" expresses best the authors' opinions as to possible solutions to some of the problems and issues they describe. They exhort that in the face of all of these newly emerging sociopolitical forces, it behooves psychiatrists to rededicate themselves to the important task of training the clinician and to maintain high standards of training amid the welter of these forces, which at times work at odds with the objectives of the psychiatric profession.

WILLIAM W. ZELLER, M.D.
Hartford, Conn.

Follow-up Study of Hospitalized Adolescents, *by Benjamin Garber, M.D. New York, Brunner/Mazel, 1972, 189 pp., $8.50.*

Both the author's brief introduction and Roy R. Grinker's foreword tacitly acknowledge that it would be wonderful if a study could be devised to validly assess the outcome of treatment. It can't be done except where genuine controls can be employed. Outcome studies of psychotherapy have been possible only under extremely limited conditions, as Meltzoff and Kornreich have recently shown (1).

Dr. Garber attempted to follow up all 164 adolescents who were hospitalized at the Psychiatric and Psychosomatic Institute of the Michael Reese Hospital from 1958 to 1968. His modest but realistic goals were to accurately describe that population and its hospital course, to determine just how the individuals were doing up to ten years after discharge, to obtain their retrospective evaluation of the treatment program they had had, and to try to relate some of the elements in the individual's hospital experience to his later level of functioning.

The first chapter is a review of the literature pertaining to follow-up of children and adolescents who have been treated. Generally, the studies have tended to confirm the expected, namely, that those children who were less seriously ill at the time of treatment were doing better at the time of follow-up. Prior to 15 years ago there were no specific, intensive residential treatment programs for adolescents, so that the comparison of follow-up studies before and after the establishment of such programs could provide some limited inferences about the effects of treatment. That possible advantage is vitiated by the high selectivity of the programs, of which the one at the Psychiatric and Psychosomatic Institute is a good example. Dr. Garber describes the hospital and the adolescent program in moderate detail and concludes that the great majority of patients are drawn from a very narrow segment of the population.

The treatment program is built around psychoanalytically oriented individual therapy, and the psychoanalytic theory of personality development provides the basis for the methodology. The essence of that is the evaluation of the degree to which the former patient has been able to solve the various tasks of the adolescent stage and advance toward independent adult living. That was accomplished by interviewing by Dr. Garber or an associate psychiatrist, codifying the interview information, and subjecting that information to blind ratings by others. In addition, the hospital records were reviewed to obtain

data on the subject's history prior to hospitalization, degree of illness during hospitalization, and various elements of experience during his stay.

Where inferences were drawn as to a correlation or cause-and-effect relationship between factors in treatment and eventual functioning, statistical analysis was used.

This volume reports a careful, diligent effort to approach the problem of treatment outcome evaluation, since its direct, valid assessment is simply impossible. It is concise and capably written and is well worth reading, not so much for the new information it contains as for its descriptions of the methods and the enormous difficulties in such an undertaking.

REFERENCE

1. Meltzoff J, Kornreich M: Research in Psychotherapy. New York, Atherton Press, 1970

WILLIAM R. FLYNN, M.D.
Encino, Calif.

Boundaries of the Soul, *by June Singer. Garden City, N.Y., Doubleday & Co., 1972, 383 pp., $10.*

Boundaries of the Soul is a somewhat misleading title, since this book is in actuality an introductory text to the practice of Jung's psychology, albeit a very good one. The author, a practicing Jungian analyst, has used extensive clinical examples to demonstrate the practical application of Jung's concepts of archetype, persona, shadow, animus, anima, complex, etc.

The text is divided into 14 chapters, each dealing with a basic aspect of the analytic process. Certain of these warrant special mention.

In chapter 3, titled "From Associations to Archetypes," the author includes several quotations from Jung on the nature of archetypes, i.e., that they are the "myth-forming," structural-forming elements of the psyche. In the following chapter she gives clinical examples of archetypal manifestations occurring in her practice. The explanation of an archetype is always difficult, but I wish that two aspects of archetypal theory had been emphasized. There is not only the universality of the archetypal experience, which the author emphasizes, but also the fact that it is experienced by each individual in his own unique way. Secondly, the archetype is expressed not only as a primordial image, but also as a typical pattern of behavior.

Chapter 5, titled "Analysis and the Counter Culture," is of great interest. The author gives several examples of college students who have experimented heavily with hallucinogenic drugs and describes in some detail how these experiences are then brought into the analytic situation, where they are assimilated in a specifically Jungian way. For the general psychiatrist this provides an illuminating view of Jungian methods of integrating symbolic material. I wish the author had also described the young chronic user of hallucinogens, because in my experience these people do not seem able to use analysis so constructively as her models did.

I have one overall reservation about the book: All the clinical examples have positive outcomes. It is natural for one to focus on his good results, but we all have our failures and not all patients are receptive to the analytic process. I keep wondering about those who get in touch with archetypal material and fail to show significant change. Aside from this, I find the book excellent. It is extremely well written and readable. The use of the clinical examples is a welcome relief because most Jungian literature is quite theoretical and abstract. One really sees in Dr. Singer's book the practical application of Jungian concepts.

THOMAS B. KIRSCH, M.D.
Palo Alto, Calif.

The Book of Family Therapy, *by Andrew Ferber, Marilyn Mendelsohn, and Augustus Napier. New York, Science House, 1972, 708 pp., no price listed.*

The fragmented, choppy quality of this book represents a strength—and at the same time, a striking weakness. It seems to be more of a smorgasbord account of an array of family therapists, and as such the book would have been more appropriately titled *The Book of Family Therapists*. It could be compared to an encounter group of family therapists who exchange personal histories and philosophies of approach to the family. Unfortunately, what is given secondary consideration is the kind of meaningful focus on the nature of family therapy suggested by Beels and Ferber on page 226: "What is needed, and what is barely in sight, is a description of treatment-approaches to different kinds of family problems."

The book tends to be biblical in scope, covering the whole area of family therapy, but the judgment rendered by Nathan Ackerman that it is "sprawling, messy, and too reflective of the diverse trends in the family field" is quite appropriate. One is provided with a diversified picture that is very much like sunlight on a multifaceted diamond, which tantalizes at the same time it is confusing, if not blinding, to the eye. However well intentioned the authors, this is an example of how hucksterism has invaded psychiatry.

Some of the high points of the book include some poignant accounts of what family therapy has meant to different individuals, particularly our clientele. I was also struck by the thoughtfulness in many spots: the warmth that was expressed in the accounts of some of the therapists' entry into family therapy. That of Carl Whitaker in particular stands out. The book should be regarded as an attempt to capture the emergence of the family movement, even though it can be regarded as an ego trip of the authors. Another high point is the reference by Laing on page 295 to the unrecognized hypnotism of children by their parents. Rabkin's chapter on crisis intervention represents a thoughtful review of this area, and it stands out in striking contrast to the diffuseness that is present in many other parts of the book.

In balance, this is an overwhelming book, where each of the subjects could justifiably become a monograph. It is a book in search of an editor, for it would have been better if it had been much more smoothly coordinated. From the vantage point of the novice in family therapy, I would suspect that the book might be more confusing than useful, insofar as there is a lack of concreteness as to what is involved in family therapy training programs. The general lack of attention to the clientele also renders this book a less than desirable scientific account of the field. There are a lot of tidbits, but not one satisfying meal.

One area that seemed to me most controversial is the chapter by Jay Haley on "Beginning and Experienced Family Therapists," in which he refers on page 155 to the therapist's problem of "how to change a family." I think that this is an inappropriate point of view. It is not the position of the therapist to change the family, but rather of the family members to become aware of how they themselves must change, and in doing so bring about a change in the family through their own efforts. Haley's aversion to history as unimportant and his identification of this view with that of the experienced family therapist run counter to the experience that many have had. What each of us is, over time, is a composite, or history, of interactions with

other people. Each of us is the embodiment not only of our physical histories but also of the way we have related to others, an expression of the cumulative experiences we have had with other people.

However, with all its limitations *The Book of Family Therapy* provides an interesting view of the vagaries of the family therapy movement. A curious reaction was that in many ways this book seems unwittingly designed to provoke a rejection of the family therapy movement by virtue of its diffuseness and its fragmented nature.

NORMAN L. PAUL, M.D.
Cambridge, Mass.

Youth: Problems and Approaches, *edited by S.J. Shamsie, M.D. Philadelphia, Lea & Febiger, 1972, 384 pp., $8 (paper).*

This book will be of wide interest to all those professionals, parents, and lay people trying to understand and help youth in facing their "old and new" conflicts in a society often in need of honest appraisal and change.

Quentin Rae-Grant in his satirical and excellent introduction observes, "Maturity has nothing with which to assert its rights to control the young to compensate for lost chances or declining powers. It has only, as has always been true, envy, now unleavened by effective authority to forbid." Most of the contributors seem to agree with his statement that "the youth has given us many lessons and, though they are the thorn in the flesh, so are they the conscience of the society."

In defense of youth's conflict, Irene Josslyn feels that "adolescents today, reared in a child centered, affluent world, seldom frustrated, taught to question everything, and desperately searching for a 'closeness,' do not see this period of development as a challenge anymore and have fewer tools with which to mature." In treatment, she stresses the importance of the therapist's own value system in dealing with youth since their own value systems are so confused. She advises the therapist to "direct, without swallowing the adolescent." In his chapter "Psychosis and Severe Individual Neurosis in Youth" William Easson emphasizes the importance of a detailed and individual evaluation of each adolescent seen.

Margaret Mead says that youth today "rejects the adult style as inappropriate to the modern world. They have no models, so that they are experimenting and setting up their own style."

On a reassuring note, the Offers, discussing their study of normal adolescence, "challenge the concept of a great inner turmoil (pathological) as being a necessary part of adolescence." They see adolescent attitudes toward sex changing more than behavior, and they have found that the normal adolescent studied rarely rejected *important* parental values. Parents are advised not to lose sight of the transient nature of adolescents' feelings despite the immediate intensity of them.

There is a general optimism in all the chapters, agreeing with Dr. Donald Holmes's statement, "Youth defines new ideas, and have always performed a vital service in the civilizing scene." Dr. Rae-Grant sums it up: "If we can accept change as the overly constant of today, and we see the challenges and opportunity in it, we can then perhaps join hands rather than locking fists in a partnership for progress with the most valuable resource of the country—its youth."

This is an excellent book—concise, direct, and informative.

BENJAMIN H. BALSER, M.D.
New York, N.Y.

Death as a Fact of Life, *by David Hendin, M.A. New York, W.W. Norton & Co., 1973, 243 pp., $7.50.*

Mr. Hendin is a medical journalist, and his style supports his reputation as a facile writer. This book is a survey of the currently available information concerning the medical, psychological, legal, and moral issues surrounding death and dying. Specifically, in addition to discussing such weighty topics as the dying patient, grief, doctors, and death, Hendin also airs the controversial themes of euthanasia, transplants, cryonic suspensions, and prevalent burial practices.

In his introduction Mr. Hendin expresses the hope that the book will serve the purpose of promoting dialogue (p. 13). It may very well accomplish his goal. However, he has been so thorough in making a case for all sides of every question that one would be hard put to find a point of departure for debate. For those seeking to argue without emotion the moral, legal, etc., aspects of death and dying, this book provides a useful reference.

Nonetheless, there are several gaps that I would like to consider. For one, much is made of the final stage of the dying process, acceptance (Kübler-Ross). Is it really acceptance of death or, rather, a useful denial? The author discusses painkillers, milieu, personal contacts, hypnosis, LSD, etc., in the terminal phase. These are meritorious measures and should be used, but because the patients wax philosophical and even poetic, is this a manifestation of acceptance or a "good trip" that encourages denial? No one has ever returned from the dead to confirm or refute either interpretation.

Closely related to this is the problem of whether or not to tell the patient that he is dying. Although not beyond discussion, the issue is academic. There are those who argue their particular views (inspired by their own unconscious emotions) and even present supporting statistics. Each side is equally vehement. In actual fact, those patients who are told go through an initial period of shock, then settle down to their denial. Those who are not told somehow know without ever asking and manage their necessary arrangements. The helper has to maintain a careful balance between firmly directing the patient toward reality and at the same time permitting the integrity of the latter's use of denial (hope).

A word about the doctor's avoidance of the dying patient. As with all humans, the physician's feelings of omnipotence have their roots in the past and their ramifications in the present. From early feelings that "the world is my apple," he develops through a normal phase of ambivalence toward those around him. His feelings of power can also give him feelings of pain—the wish equates with the deed. If his wish comes true, lex talionis will prevail. This residue persists in the doctor's unconscious. With awareness that his patient will die, he is compelled by unrealistic guilt and accountability to turn away before the patient dies, thus avoiding retribution.

This book is a welcome addition to the ever-expanding literature on death and dying, a recent development for which I am grateful. Unfortunately, much of the current material consists of intellectual exercises, a kind of morbid fascination that reflects a denial of fears about the subject and one's own mortality. It is analogous to the way people in public stare at a physically deviant person with intense fascination and apprehension. It would be worthwhile to look around at those who are staring so hard at the deviant (the dying person) and consider *their* reactions and motivations.

The author has been energetic in his research and his gleaning from many authorities, and he has come up with an excellent tutorial. While this book will not be novel to the psychiatrist, it is

an eminently readable source of enlightened reference for the lay public.

NATHAN SCHNAPER, M.D.
Baltimore, Md.

Healing Through Living: A Symposium on Residential Treatment, *compiled and edited by Morris F. Mayer, Ph.D., and Arthur Blum, D.S.W. Springfield, Ill., Charles C Thomas, 1971, 209 pp., $15.50.*

In 1968, Bellefaire, a residential treatment center for children and adolescents in Cleveland, Ohio, celebrated its 100th anniversary with a three-day symposium. Most of the papers published here are drawn from this meeting. The content reflects Bellefaire's primary interest in milieu treatment (group living), special education, and psychotherapy.

By coincidence this book reached my desk just as I was completing my first year as director of an inpatient service for children and as I was trying to organize my thoughts on residential treatment for presentation to a new group of fellows in child psychiatry. I was delighted to see that this book held up under the stress of my high expectations and needs.

The book is clearly psychoanalytic in its orientation, but rather than being used in a dry or theoretical way the theory provides the scaffolding from which one can approach the myriad issues of residential treatment.

Morris Mayer opens the series with a discussion of the separation process that residence entails and the termination process that is inevitable upon reaching the therapeutic goal. Joseph Noshpitz beautifully struggles with the ever-present role problem of the psychotherapist in a residential setting. It is not *which* aspect of a residence is most important but rather what each can contribute—when and with what goal in mind. Several clinical cases are presented to illustrate the kind of teamwork that is so essential for this engulfing type of treatment to be successful. William Schwartz presents a masterful article in which he conceptualizes the tasks of the child care worker, how to identify them, and the skills necessary to carry them out. I found this article particularly useful.

This is not a how-to book. It is one that attacks some of the current crucial issues of this complex field of residential treatment. Unfortunately, the book seems unduly expensive, although it is attractively laid out. I recommend it highly to those who have an enthusiastic interest in and commitment to this field.

PETER BLOS, JR., M.D.
Ann Arbor, Mich.

Briefer Notice

Briefer notice does not imply a judgment; it simply means that the reviewers have evaluated the books in fewer words than in the previous section.

The Science of Behavior and the Image of Man, *by Isidor Chein. New York, Basic Books, 1972, 336 pp., $12.50.*

In this book Professor Chein challenges his fellow psychologists to look beyond the narrow confines of experimental research in order to view man as an active and free agent who must account for himself to justify his own existence, and not as a helpless, powerless reactor or an impotent robot.

To make his point, and writing in the first person, the author systematically deals with the meaning of freedom and the nature of motivation. He proceeds to criticize the model of motivation as a passive tension-reducing concept, and instead he expresses the view that motivation implicitly involves perception, learning, memory, inference, meaning, and all other psychological processes that one may want to add, but in the final analysis it implies a commitment to try to accomplish something.

Although Chein does not regard himself as being qualified to write a philosophical book, this is in fact what he did, and he did it very well. Of particular interest, for example, is his excellent historical survey of the body-mind controversy.

Without a doubt this book will be criticized by some as being too theoretical, while others will find it controversial. However, those who look upon man as something more than the sum total of his reflexes will appreciate Chein's clarity, his powerful arguments, and above all his humanism.

PETER E. SIFNEOS, M.D.
Boston, Mass.

Diseases of the Nervous System, *by W.B. Matthews, D.M., and Henry Miller, M.D., D.P.M. Philadelphia, F.A. Davis Co. (U.S. distributor), 1972, 342 pp., $13.25.*

This well-written neurologic textbook is intended primarily for students. However, all physicians who are concerned with neurologic patients will find the clinical descriptions of diseases helpful. The authors write with a clarity that is unusual in medical texts, and from considerable clinical experience. The book deserves a place in the personal library of all who are interested in neurologic disease.

The absence of any semblance of a bibliography would make this book a poor choice for the serious student. Further, the authors stress their own personal views without identifying them as such, i.e., "Asymptomatic cancer is today one of the commonest causes of subacute polyneuritis." This, in the absence of a bibliography, would make the book a poor choice if one were to purchase only one reference book for the field of neurology.

DONALD W. MULDER, M.D.
Rochester, Minn.

Psychology in the USSR: An Historical Perspective, *edited by Josef Brožek and Dan I. Slobin. White Plains, N.Y., International Arts and Sciences Press, 1972, 301 pp., $15.*

The main body of this book consists of translations of several Soviet articles commemorating the 50th anniversary of Soviet psychology in 1967. To these the editors have added a wealth of supplementary material including some brief pieces previously published by Brožek in the *American Psychologist, Contemporary Psychology,* and *Science;* a chronology of historical events in Soviet psychology; brief biographies, often with portraits, of prominent Soviet psychologists; several bibliographies, some annotated; a key to the transliteration system used; and a glossary. With all this supplemental material, the absence of an index is both noticeable and disappointing.

Since the material is archival rather than interpretive, any

definite perspective is left to the reader to structure. Thus the book serves not as an introduction to Soviet psychology but rather as a working paper for those already acquainted with the subject who may wish to extend their acquaintance further. For them it should be a valuable source book.

As the preface notes, the Russian contributions do give a revealing self-portrait of Soviet psychology, however realistic it may or may not be. Except for the persistent evaluative application of Marxist ideology, any personal interaction of a critical nature seems missing. Like the rest of the book, this material is archival in nature and primarily straight narration. Perhaps this is forced by their commemorative purpose. All in all, one gets the impression that the Soviet effort to find a uniquely Marxist basis for psychology has not been too successful or too stimulating.

WILLIAM A. HUNT, PH.D.
Chicago, Ill.

Counseling Parents of the Emotionally Disturbed Child, *edited by Robert L. Noland. Springfield, Ill., Charles C Thomas, 1972, 417 pp., $11.50.*

The outdated stereotype of child psychiatry as a field of practice limited to direct interventions solely with children has remarkable durability. This book serves a useful purpose in altering that image by drawing attention to the literature of the 1950s and early 1960s on parent involvement in the treatment of children and adolescents.

Among the collection of 30 papers are several classics from the late 1940s and early 1950s by Hilde Bruch, William Langford, and O. Spurgeon English. Their writings illustrate the concern then about ways of involving parents in child psychotherapy. The other chapters deal with specific issues in parent counseling and therapeutic techniques applicable to mothers and fathers. Special emphasis is placed upon group therapy with the parents of emotionally disturbed children.

Because this book does not include modern developments in family diagnosis and therapy, clinicians will find its value to be primarily historical. The techniques described should be relevant to the work of school and pastoral counselors.

JACK C. WESTMAN, M.D.
Madison, Wis.

Mental Health Services for the Mentally Retarded, *edited by Elias Katz, Ph.D. Springfield, Ill., Charles C Thomas, 1972, 264 pp., $12.75.*

This book presents compendiums of many aspects of direct and indirect mental health services that could be used by and for the mentally retarded, as well as information on specific mental health problems of the mentally retarded. Each of the 19 contributors is distinguished in his field.

The book developed out of the belief that at present there is very little available in mental health services to assist in the prevention and treatment of the frequent acute and chronic emotional and behavior disorders affecting many of the mentally retarded.

The broad coverage of the subjects has been well organized by the editor. Early chapters present basic considerations in mental health services and their applicability to the mentally retarded. Several chapters discuss specific mental health problems of the retarded and indicate directions for prevention and intervention. The roles of family members and professionals who affect the mental health of the retarded are emphasized. Final chapters discuss possibilities and directions for organization of community services and training in delivery of mental health services.

There is a uniform philosophical theme of hope evident in all of the presentations, plus knowledge of the enlightened and practical approaches to education, treatment, and living patterns that are becoming more readily available to the mentally retarded.

The compilation of information and possible directions that could be developed to make mental health services available will be of interest to all professionals working with the mentally retarded, as well as mental retardation administrators at local, state, and federal levels and mental health community services planners and administrators.

BEATRICE R. FLEESON, R.N.
Hartford, Conn.

Psychiatric Complications of Medical Drugs, *edited by Richard I. Shader, M.D. New York, Raven Press, 1972, 387 pp., $14.50.*

This is an excellent book. Its 13 chapters include descriptions of digitalis toxicity, the biology of cortisol metabolism, and mental effects of reserpine and of L-dopa as well as the behavioral changes produced by numerous other frequently prescribed substances. The contributors were indeed thorough, as is evidenced by the chapter on digitalis toxicity, which has 129 references.

It is unfortunate that this volume does not have a more inclusive title, because there are numerous concise discussions that go far beyond a description of psychiatric complications. For example, the chapter on hormones and behavior includes such sections as "The Effects of Experience on the Endocrine State" and "Mechanism of Brain-Hormone Interaction," which are areas not fraught with clarity for some in this specialty.

Too, the chapter on vitamins has a stimulating critique of the Hoffer-Osmond theory, and the final subject covered is a very thorough discussion of placebo effects. This book is sufficiently detailed to be recommended for reading and for reference; in fact, this or a similar work would seem essential to anyone doing routine consultations in other fields of medicine.

JACKSON A. SMITH, M.D.
Maywood, Ill.

This Month's Reviewers

MONTAGUE ULLMAN, M.D., is Director, Department of Psychiatry, Maimonides Medical Center, Brooklyn, N.Y.

EVEOLEEN N. REXFORD, M.D., is Professor and Director of Child Psychiatry, Boston University School of Medicine, Boston, Mass.

MAURICE J. BARRY, JR., M.D., is Consultant in Psychiatry, Mayo Clinic, Rochester, Minn.

WILLIAM W. ZELLER, M.D., is Director of Psychiatric Education, Institute of Living, Hartford, Conn.

WILLIAM R. FLYNN, M.D., is in private practice in Encino, Calif.

THOMAS B. KIRSCH, M.D., is Clinical Instructor, Department of Psychiatry, Stanford Medical School, Stanford, Calif., and Training Consultant, Agnews State Hospital, San Jose, Calif.

NORMAN L. PAUL, M.D., is Assistant Clinical Professor of Psychiatry, Harvard Medical School, Boston, Mass.

BENJAMIN H. BALSER, M.D., is Special Lecturer in Psychiatry, Columbia University College of Physicians and Surgeons, New York, N.Y.

NATHAN SCHNAPER, M.D., is Clinical Associate Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, Md.

PETER BLOS, JR., M.D., is Director, Inpatient Service, Children's Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor, Mich.

PETER E. SIFNEOS, M.D., is Associate Director, Psychiatric Services, Beth Israel Hospital, Boston, Mass.

DONALD W. MULDER, M.D., is Consultant, Department of Neurology, Mayo Clinic, Rochester, Minn.

WILLIAM A. HUNT, Ph.D., is Professor of Psychology, Loyola University of Chicago, Ill.

JACK C. WESTMAN, M.D., is Professor of Psychiatry, University of Wisconsin Medical School, Madison, Wis.

BEATRICE R. FLEESON, R.N., is Executive Director, The Greater Hartford Association for Retarded Children, Inc., Hartford, Conn.

JACKSON A. SMITH, M.D., is Professor and Chairman, Department of Psychiatry, Loyola University Stritch School of Medicine, Maywood, Ill.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

Alcohol and Health, *Report from the Secretary of Health, Education, and Welfare. New York, Charles Scribner's Sons, 1973, 360 pp., $3.95 (paper).*

Mental Health in the Developing World: A Case Study in Latin America, *by Mario Argandoña, M.D., and Ari Kiev, M.D. New York, Free Press (Macmillan Co.), 1972, 170 pp., $7.95.*

La Psychothérapie institutionnelle chez l'enfant, *by Dr. Henry Aubin. Vendôme, France, Presses Universitaires de France, 1973, 208 pp., no price listed (paper).*

Mary Barnes: Two Accounts of a Journey Through Madness, *by Mary Barnes and Joseph Berke. New York, Ballantine Books, 1973, 374 pp., $1.95 (paper).*

Piaget: Dictionary of Terms, *by Antonio M. Battro, translated and edited by Elizabeth Rütschi-Herrmann and Sarah F. Campbell. Elmsford, N.Y., Pergamon Press, 1973, 186 pp., $14.*

Between Consenting Adults: Dialogue for Intimate Living, *by Cathrina Bauby, M.S. New York, Macmillan Co., 1973, 292 pp., $7.95.*

Critical Incidents in Child Care: A Case Book for Child Care Workers, *edited by Jerome Beker, Ed.B. Morningside Heights, N.Y., Behavioral Publications, 1972, 368 pp., $7.95 (paper).*

Neurological Examination in Clinical Practice, 3rd ed., *by Edwin R. Bickerstaff, M.D. Philadelphia, F.A. Davis Co. (U.S. distributor), 1973, 342 pp., $21.*

The Yearbook of Drug Abuse, *edited by Leon Brill, M.S.S., and Ernest Harms, Ph.D. Morningside Heights, N.Y., Behavioral Publications, 1973, 386 pp., $19.95.*

Major Modalities in the Treatment of Drug Abuse, *edited by Leon Brill, M.S.S., and Louis Lieberman, M.A. Morningside Heights, N.Y., Behavioral Publications, 1972, 313 pp., $12.95.*

The Relevance of Education, *by Jerome S. Bruner, edited by Anita Gil. New York, W.W. Norton & Co., 1973, 170 pp., $2.45 (paper).*

Methadone: Experiences and Issues, *edited by Carl D. Chambers, Ph.D., and Leon Brill, M.S.S. Morningside Heights, N.Y., Behavioral Publications, 1973, 411 pp., $19.95.*

Naissance du Psychanalyste: De Mesmer à Freud, *by Dr. L. Chertok and Dr. R. de Saussure. Paris, Payot, 1973, 273 pp., 48 40 F (paper).*

Understanding Your Child from Birth to Three, *by Joseph Church. New York, Random House, 1973, 260 pp., $6.95.*

Reference Group Theory and Delinquency, *by Robert E. Clark, Ph.D. Morningside Heights, N.Y., Behavioral Publications, 1972, 123 pp., $4.95 (paper).*

Psychological Survival: The Experience of Long-Term Imprisonment, *by Stanley Cohen and Laurie Taylor. New York, Pantheon Books (Random House), 1973, 217 pp., $6.95.*

Human Development and Adjustment, *by Lester D. Crow, Ph.D., L.H.D., and Thomas F. Graham, Ph.D. Totowa, N.J., Littlefield, Adams & Co., 1973, 316 pp., $2.50 (paper).*

An Introduction to Psychopathology, 3rd ed., *by D. Russell Davis, M.A., M.D. New York, Oxford University Press, 1973, 181 pp., $5.95 (paper).*

A Silent Tragedy: Child Abuse in the Community, *by Peter and Judith DeCourcy. Port Washington, N.Y., Alfred Publishing Co., 1973, 231 pp., $6.95.*

Genetic Diversity and Human Equality, *by Theodosius Dobzhansky. New York, Basic Books, 1973, 123 pp., $5.95.*

Dominique: Analysis of an Adolescent, *by Françoise Dolto, translated by Ivan Kats. New York, E.P. Dutton & Co. (distributor), 1973, 262 pp., $8.95.*

Psychiatry Continuing Education Review, *by William M. Easson, M.D., Lane A. Gerber, Ph.D., and Marvin E. Gottlieb, M.D. Flushing, N.Y., Medical Examination Publishing Co., 1973, 152 pp., $10 (paper).*

The Understanding of the Brain, *by John C. Eccles. New York, McGraw-Hill Book Co., 1973, 238 pp., $3.95 (paper).*

The Development of Freud's Thought, *by Reuben Fine, Ph.D. New York, Jason Aronson Book Publishers, 1973, 296 pp., $10.*

Statistical Methods for Rates and Proportions, *by Joseph L. Fleiss, Ph.D. New York, John Wiley & Sons, 1973, 208 pp., $12.95.*

The Headache Book, *by Arnold P. Friedman, M.D., Shervert H. Frazier, Jr., M.D., with Dodi Schultz. New York, Dodd, Mead & Co., 1973, 173 pp., $5.95.*

Frontiers in Neuroendocrinology, 1973, *edited by William F. Ganong, M.D., and Luciano Martini, M.D. New York, Oxford University Press, 1973, 413 pp., $19.95.*

Law of Hospital, Physician and Patient, 3rd ed., *by Emanuel Hayt, LL.B., Lillian R. Hayt, J.D., and August H. Groeschel, M.D. Berwyn, Ill., Physicians' Record Co., 1973, 1165 pp., no price listed.*

Resocialization: An American Experiment, *by Daniel B. Kennedy, Ph.D., and August Kerber, Ph.D. Morningside Heights,*

N.Y., Behavioral Publications, 1973, 186 pp., $4.95 (paper).

Behavior Influence and Personality: The Social Matrix of Human Action, *by Leonard Krasner and Leonard P. Ullmann. New York, Holt, Rinehart and Winston, 1973, 546 pp., no price listed.*

Encounter Groups: First Facts, *by Morton A. Lieberman, Irvin D. Yalom, and Matthew B. Miles. New York, Basic Books, 1973, 486 pp., $15.*

Theories of Personality: Primary Sources and Research, 2nd ed., *edited by Gardner Lindzey, Ph.D., Calvin S. Hall, Ph.D., and Martin Manosevitz, Ph.D. New York, John Wiley & Sons, 1973, 479 pp., $10.95.*

Zaboravljena Božanstva (The Forgotten Gods), *by Vojin Matić. Belgrade, Yugoslavia, Prosveta, 1972, 205 pp., no price listed.*

Illness, Immunity, and Social Interaction: The Dynamics of Biosocial Resonation, *by Gordon Ervin Moss, Ph.D. New York, John Wiley & Sons, 1973, 275 pp., no price listed.*

The Art of Dying, *by Robert E. Neale. New York, Harper & Row, 1973, 158 pp., $5.95.*

The Child and Reality: Problems of Genetic Psychology, *by Jean Piaget, translated by Arnold Rosin. New York, Grossman Publishers, 1973, 174 pp., $7.95.*

The Making of a Mental Patient, *edited by Richard H. Price and Bruce Denner. New York, Holt, Rinehart and Winston, 1973, 373 pp., no price listed (paper).*

Artistry of the Mentally Ill, *by Hans Prinzhorn, translated by Eric von Brockdorff. New York, Springer-Verlag, 1972, 274 pp., $19.80.*

Nānā I Ke Kumu (Look to the Source), vol. 1, *by Mary Kawena Pukui, E.W. Haertig, M.D., and Catherine A. Lee. Honolulu, Hui Hānai, Queen Liliuokalani Children's Center, 1972, 213 pp., no price listed (paper).*

Functional Aids for the Multiply Handicapped, *edited by Isabel P. Robinault, Ph.D. Hagerstown, Md., Medical Department, Harper & Row, 1973, 224 pp., $10.*

The Etiology of Alcoholism: Constitutional, Psychological and Sociological Approaches, *by Julian B. Roebuck, Ph.D., and Raymond G. Kessler, M.A. Springfield, Ill., Charles C Thomas, 1972, 235 pp., $11.95.*

The Panic of the Gods and Other Essays, *by Géza Róheim, edited by Werner Muensterberger. New York, Harper & Row, 1972, 227 pp., $12.50 (hardback), $3.95 (paper).*

The First Freudians, *edited by Hendrik M. Ruitenbeek, Ph.D. New York, Jason Aronson Book Publishers, 1973, 269 pp., $10.*

Freud As We Knew Him, *edited by Hendrik M. Ruitenbeek. Detroit, Wayne State University Press, 1973, 518 pp., $17.50.*

Psychodynamically Based Psychotherapy, *by Leon J. Saul, M.D. New York, Jason Aronson Book Publishers, 1973, 836 pp., $20.*

Sybil, *by Flora Rheta Schreiber. Chicago, Henry Regnery Co., 1973, 349 pp., $8.95.*

Splitting: A Case of Female Masculinity, *by Robert J. Stoller, M.D. New York, Quadrangle Books, 1973, 395 pp., $9.95.*

Behavior Therapy with Delinquents, *compiled and edited by Jerome S. Stumphauzer, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 350 pp., $11.95.*

Residential Treatment of Emotionally Disturbed Children, *edited by George H. Weber, Ph.D., and Bernard J. Haberlein, M.A. Morningside Heights, N.Y., Behavioral Publications, 1972, 327 pp., $14.95.*

Call No Man Normal, *by Benjamin B. Wolman, Ph.D. New York, International Universities Press, 1973, 322 pp., $12.*

Neurological Surgery, volumes 1, 2, 3, *edited by Julian R. Youmans, M.D., Ph.D. Philadelphia, W.B. Saunders Co., 1973, 2024 pp., $114, the set.*

Socialization and Personality Development, *edited by Edward Zigler, Ph.D., and Irvin L. Child, Ph.D. Reading, Mass., Addison-Wesley Publishing Co., 1973, 397 pp., $5.95 (paper).*

OFFICIAL ACTIONS

Highlights of the 126th Annual Meeting

The 126th Annual Meeting of the American Psychiatric Association was held in Honolulu, Hawaii, May 7–11, 1973. The total registration was 7,616, including 3,318 members, 1,421 nonmembers, 322 scientific exhibitors, 74 members of the press, 284 program participants, and 2,197 spouses and families of members.

The opening session, on Monday morning, May 7, was brought to order by Perry C. Talkington, M.D., 101st President of the Association. After the Hawaiian blessing, given by the Reverend Abraham K. Akaka, Kawaiahao Church, Honolulu, the Kamehameha High School Boys and Girls Glee Clubs sang a number of selections.

Official greetings were extended by the Honorable George R. Ariyoshi, Lieutenant Governor of the State of Hawaii, and by the Honorable Frank F. Fasi, Mayor of the City and County of Honolulu. Dr. Talkington then introduced the distinguished guests, who included: Dr. Tolani Asuni, President, Association of Psychiatrists in Africa; Dr. Andrew Bennett, representing the Australian and New Zealand College of Psychiatrists; Dr. Nathan Beck, President, Canadian Psychiatric Association; Dr. Edmund Casy, President, National Medical Association; Dr. Tsung-Yi Lin, representing the World Federation for Mental Health; Dr. Joseph Merin, President, American Academy of Psychoanalysis; Dr. Burness Moore, President, American Psychoanalytic Association; Dr. George Moorhead, representing the American Public Health Association; Dr. Joseph Noshpitz, President-Elect, the American Academy of Child Psychiatry; Dr. Clovis Martins, President, Inter-American Council of Psychiatric Associations and Past President of the Latin American Psychiatric Association; Chaplain John Smith, President, Association of Mental Health Chaplains; and Dr. Howard Rome, President, World Psychiatric Association.

Dr. Talkington introduced Melvin Sabshin, M.D., Chairman of the Program Committee; George Schnack, M.D., Chairman of the Task Force on Arrangements; and Milton Greenblatt, M.D., and Judd Marmor, M.D., Vice-Presidents.

Vice-President Milton Greenblatt, M.D., then introduced Dr. Talkington, who gave the presidential address, "A Time for Action," and Vice-President Judd Marmor, M.D., introduced Alfred M. Freedman, M.D., who gave the response of the President-Elect. (The texts of these addresses are published elsewhere in this issue of the *Journal*.)

The opening session was closed with a benediction by the Reverend Yoshiaki Fujitani, Honpa Hon Hongwanji Mission, Honolulu.

The scientific sessions began Monday afternoon, May 7. There were 297 papers presented in regular sessions, as well as an additional 36 papers on new research that were presented in four sessions throughout the week. There were 49 morning panels and 58 evening panels, three videotaped special sessions concerning continuing education for psychiatrists, 12 live learning demonstrations, 18 films, and six transcultural film features. The Benjamin Rush Lecture, "The Use of Stills in the Study of Gender Display," was presented by Erving Goffman, Ph.D., Benjamin Franklin Professor of Anthropology and Sociology, University of Pennsylvania, Philadelphia. Paul T. K. Lin, Ph.D., Director, Center for East Asian Studies, McGill University, Montreal, Que., Canada, gave the Adolf Meyer Lecture, "Medicine and Society—the Dynamics of Change in the Peoples Republic of China." Two Special Lectures were given, "Community Mental Health in Great Britain," by Douglas Bennett, M.D., D.P.M., Institute of Psychiatry, the Maudsley Hospital, London, England, and "Psychiatric Care in Africa," by Tolani Asuni, M.D., D.P.M., Medical Superintendent, the Aro Hospital, Abeokuta, Nigeria.

CONVOCATION

The 17th Convocation of Fellows was held in the Coral Ballroom of the Hilton Hawaiian Village Hotel on Monday, May 7. Dr. Talkington presided. After the processional march, Dr. Talkington called the Convocation to order, and the Right Reverend Monsignor Charles A. Kekumano, St. Anthony's Church, Maui, gave the invocation. The life fellows and fellows were inducted by Alfred M. Freedman, M.D., President-Elect.

The following were made Honorary Fellows: Elizabeth Monroe Boggs, Ph.D., Hampton, N.J.; Leo Srole, Ph.D., New York, N.Y.; Arnold Stone, LL.D., Los Angeles, Calif.; Robert L. Robinson, Washington, D.C.; and the Reverend Ernest Bruder, Washington, D.C. Life fellows and life members who had been in the Association for 50 years were introduced by the President. They are: Oswald H. Boltz, M.D., Binghamton, N.Y.; Henry B. Elkind, M.D., Boston, Mass.; Frederic H. Leavitt, M.D., Philadelphia, Pa.; Clarence R. Miller, M.D., Austin, Tex.; and Lloyd J. Thompson, M.D., Chapel Hill, N.C.

The presentation of awards followed. Dr. Talkington presented the Distinguished Service Award—given to APA members "whose distinguished careers have ennobled the profession of psychiatry"—to George Tarjan, M.D., Professor of Psychiatry and Program Director for Mental Retardation, University of California School of Medicine and School of Public Health at Los Angeles.

The Lester N. Hofheimer Prize for Research, presented by Leon Epstein, M.D., was given to Elsie R. Broussard, M.D., and Miriam Sergay Sturgeon Hartner, M.D., for their study "The Maternal Perception of the Neonate as Related to Development" and jointly to Irving I. Gottesman, Ph.D., and James Shields for their study "Schizophrenia and Genetics: A Twin Study Vantage Point." This award is given "to honor U.S. research investigators for outstanding accomplishment in psychiatry and mental hygiene."

Drs. Broussard and Hartner are with the Graduate School of Public Health, University of Pittsburgh, Pa., where Dr. Broussard is Professor of Public Health Psychiatry and Dr. Hartner is Adjunct Assistant Professor, Community Mental Health Program. Dr. Gottesman is with the Department of Psychology, University of Minnesota, Minneapolis, and Mr. Shields is

Lecturer, Institute of Psychiatry, Denmark Hill, London, England.

Norbert B. Enzer, M.D., presented the Agnes Purcell McGavin Award to William S. Langford, M.D., Emeritus Professor of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, N.Y., for his "outstanding contributions to the prevention of mental disorders in children."

The Robert T. Morse Writers Award was presented by Zigmond M. Lebensohn, M.D., to Mr. Alton Blakeslee, science reporter, Associated Press, New York, N.Y., and to Mr. Frank Carey, science reporter, Associated Press, Washington, D.C. This award is given to "honor popular writers who have made major contributions to the public understanding of psychiatry over an extended period of time."

Morton Birnbaum, M.D., Brooklyn, N.Y., received the Manfred S. Guttmacher Award for his paper "The Right to Treatment—Some Comments on Implementation." The award, which was presented by Jonas R. Rappeport, M.D., is given "for an outstanding contribution to forensic psychiatry in the form of a book, monograph, or paper submitted to, or presented at, any professional meeting, or published in the preceding calendar year."

The Seymour D. Vestermark Prize Award, given for "outstanding contributions to undergraduate and postgraduate medical education, to continuing education, and to the education of behavioral scientists for research," was presented by William Malamud, M.D., to Raymond Feldman, M.D., Boulder, Colo.

The District Branch Newsletter of the Year Award was presented by Robert J. Campbell III, M.D., to the newsletter of the Louisiana Psychiatric Association, Robert L. Newman, M.D., editor. This award recognizes "the overall excellence of outstanding newsletters published by the District Branches of the Association from the standpoint of editorial content, attractiveness of format, and usefulness in furthering communication within the profession."

Following presentation of the awards, Francis L. K. Hsu, Ph.D., Professor of Anthropology, Northwestern University, Evanston, Ill., gave the William C. Menninger Memorial Convocation Lecture. Dr. Hsu spoke on "Psychosocial Homeostasis (PSH): Toward a Sociocentric View of Man." The Convocation then recessed.

BUSINESS SESSION

For the second year the business session was convened as a meeting of the Assembly of District Branches acting for the membership in receiving reports of the officers and actions of the Board of Trustees. The meeting was held on Tuesday, May 8, in the Kauai and Maui rooms of the Sheraton-Waikiki Hotel, with Dr. Talkington presiding. After a memorial to deceased members and fellows, Francis J. Braceland, M.D., gave a memorial to Past President Karl Bowman, M.D.

Morris Kleinerman, M.D., Chairman, Committee of Tellers, then announced the results of the election of officers and trustees and of the vote on the proposed amendments to the Constitution and By-Laws. The new President-Elect is John P. Spiegel, M.D.; the Vice-Presidents are Harold M. Visotsky, M.D., and Mildred Mitchell-Bateman, M.D.; the Secretary is Robert W. Gibson, M.D.; and the Treasurer is Jack Weinberg, M.D. Leon Eisenberg, M.D., is Trustee-at-Large, and the Area I Trustee is Alan A. Stone, M.D.

The Area IV Trustee was not announced because it was believed that the vote count was incorrect. Robert B. Neu, M.D., moved that the matter be referred back to the Board of Trustees for reconsideration and investigation. This motion was passed by the voting members of the Assembly of District Branches.

The reports of the officers to the membership followed. Robert W. Gibson, M.D., gave the Secretary's report, which included actions of the Board of Trustees, followed by Hayden H. Donahue, M.D., who gave the Treasurer's report. James C. Johnson, Jr., M.D., gave the report of the Speaker of the Assembly of District Branches, and Warren S. Williams, M.D., gave the report of the Speaker-Elect. The Medical Director, Walter E. Barton, M.D., gave his report, and the Chairman of the Committee on Constitution and By-Laws, Warren S. Williams, M.D., gave his.

Dr. Williams presented a number of proposed amendments to the Constitution and By-Laws that the Board of Trustees and the Assembly of District Branches had approved. Dr. Robert Gibson then presented 12 proposed amendments that had been received by petition. No action was to be taken on these amendments at that time.

Under old business, a motion was made from the floor to add an amendment to the position statement on confidentiality of the American Psychoanalytic Association. This motion was ruled out of order.

Under new business, Howard Rome, M.D., requested help from the membership in recommending to the Search Committee individuals to fill the post of APA Medical Director when Walter Barton, M.D., the current Medical Director, retires in 1974.

Alan Becker, M.D., moved that the Assembly pass the following resolution:

> The President of the American Psychiatric Association is called upon to write to the President of the Soviet Academy of Sciences:
>
> (a) reiterating the APA policy against use of mental commitment for political purposes,
>
> (b) expressing our concern for the use of mental commitment as a weapon against Soviet Jews and others wishing to emigrate,
>
> (c) calling for revocation of the Soviet law providing payment of educational fees for emigrants.

It was moved, seconded, and passed that the Assembly Executive Committee transmit this resolution to the area councils and to the Board of Trustees for their consideration. The business session was then formally adjourned, and a forum was held with open discussion from the floor.

During the forum, Isidore Ziferstein, M.D., proposed a resolution recommending that APA endorse an end to the hostilities in Southeast Asia. The resolution did not carry. The proposed amendment to the American Psychoanalytic Association's position statement on confidentiality was passed.

MEETINGS OF THE BOARD OF TRUSTEES

The Board of Trustees met in regular sessions on Saturday and Sunday, May 5 and 6, and on Thursday, May 10. Among other actions, the Board approved the New Hampshire Psychiatric Society as a new district branch. At its special meeting on Wednesday, May 9, the Board announced that the original vote tabulation for Area IV Trustee was incorrect and that Herbert Klemmer, M.D., will be the new Area IV Trustee.

ANNUAL BANQUET

The Hawaiian Banquet and Pageant were held on Wednes-

day, May 9, in the Coral Ballroom of the Hilton Hawaiian Village Hotel. Dr. Talkington introduced distinguished guests and presented Past Vice-Presidents' badges to Drs. Marmor and Greenblatt. He also presented the Past Speaker's plaque to Dr. James Johnson. Raymond Waggoner, M.D., President, 1969–1970, presented Dr. Talkington with the Past President's badge, and Dr. Talkington presented the President's Medallion to the incoming President, Alfred M. Freedman, M.D. A Polynesian review followed, featuring songs and dances from ancient to modern times. Dancing followed the entertainment.

SPOUSES' ACTIVITIES: ENTERTAINMENT

This year the chairwoman of the leisure time activities was Mrs. George F. Schnack, and the co-chairwomen were Mrs. Bryon A. Eliashof and Mrs. John F. McDermott, Jr. Mrs. Walter F. Char was the hospitality chairwoman.

The committee provided entertainment throughout the week, including a house and garden tour; arts and crafts of Hawaii; a fashion show covering 200 years of Hawaiian dress, which was presented in the Monarch Room of the Royal Hawaiian Hotel; an evening at Sea Life Park, where trained porpoises and whales could be viewed; and a walking tour of some historic sights in Honolulu.

In addition, many optional tours and events were offered. These included a tour of the city of Honolulu, cruises of Pearl Harbor, and trips to Paradise Park, where there are six reproductions of villages, including Tongan, Hawaiian, Tahitian, Fijian, Maori, and Samoan villages, and where information about the customs and culture of each was exchanged through talk, dance, song, pageantry, and food.

ROBERT W. GIBSON, M.D.
Secretary, American Psychiatric Association

The American Board of Psychiatry and Neurology

The following are those who successfully completed the Board examination given in Boston, Mass., April 2–3, 1973.

PSYCHIATRY

Allen, J. Scott, M.D., Orchard Lake, Mich.
Battin, Isaac L., Jr., M.D., Long Meadow, Mass.
Bauermeister, Martin, M.D., Madison, Conn.
Belfer, Myron L., M.D., Brookline, Mass.
Bergman, David B., M.D., San Diego, Calif.
Bhoothalingom, Easwara, M.D., Baltimore, Md.
Black, Edward, M.D., Washington, D.C.
Bondurant, William W. III, M.D., Galveston, Tex.
Bowdan, Newton D., M.D., South Hadley, Mass.
Brown, Jack R., M.D., Seattle, Wash.
Byrne, Luis O., M.D., MacClenny, Fla.
Chen, Albert King-Cent, M.D., Wingdale, N.Y.
Cheren, Stanley, M.D., Chestnut Hill, Mass.
Chiles, John A., M.D., Madison, Wis.
Cimonetti, Thomas C., M.D., Columbia, Md.
Clark, Corydon G., M.D., Sacramento, Calif.
Clausen, Jerry L., M.D., Syracuse, N.Y.
Cohen, Gary H., M.D., New Orleans, La.
Cohn, Lawrence S., M.D., Miami, Fla.
Colombel, George I., M.D., Cincinnati, Ohio
Culbertson, Eugene C., M.D., Escondido, Calif.
Davis, Steven J., M.D., San Diego, Calif.
Davison, Walter T., M.D., Rockville, Md.
Delaplane, James M., M.D., Philadelphia, Pa.
Delisi, Samuel D., M.D., River Forest, Ill.
Diaz, Humberto, M.D., Albuquerque, N. Mex.
DiGangi, Mary V., M.D., New York, N.Y.
Donaldson, John Y., M.D., Omaha, Neb.
Donovan, William B., M.D., San Antonio, Tex.
Dowling, Patrick J., M.D., New Orleans, La.
Ebaugh, Irvin A., Jr., M.D., Dallas, Tex.
Egan, James, M.D., New York, N.Y.
Eiland, Murray L., M.D., Berkeley, Calif.
Estess, Michael E., M.D., Houston, Tex.
Feldshuh, Benjamin, M.D., New York, N.Y.
Fisher, Robert B., M.D., Honolulu, Hawaii
Fluegel, John O., M.D., Minneapolis, Minn.
Fosser, Hector, M.D., Norristown, Pa.
Friedman, Raymond J., M.D., West Los Angeles, Calif.
Friedman, Richard C., M.D., New York, N.Y.
Fryer, John E., M.D., Philadelphia, Pa.
Fuller, Lois B., M.D., Edmonton, Alberta, Canada
Gates, Christopher C., M.D., Brookline, Mass.
Gillin, John C., M.D., Bethesda, Md.
Glass, Simon D., M.D., Oklahoma City, Okla.
Glickman, Joseph M., M.D., Burlingame, Calif.
Goldfine, Lee M., M.D., Santa Monica, Calif.
Goldman, Adila S., M.D., New York, N.Y.
Grasso, Ralph J., M.D., Boulder, Colo.
Greenstein, Robert A., M.D., Bala Cynwyd, Pa.
Gross, Lillian, M.D., Great Neck, N.Y.
Gurland, David B., M.D., Tucson, Ariz.
Hann, Marek J., M.D., Madison, Wis.
Harris, Louis C., Jr., M.D., Philadelphia, Pa.
Hawkins, David M., M.D., Durham, N.C.
Hefter, Gilbert M., M.D., Chicago, Ill.
Henderson, Peter B., M.D., Pittsburgh, Pa.
Herrick, Robert H., M.D., Ross, Calif.
Hertzberg, Leonard J., M.D., Baltimore, Md.
Heston, Julie, M.D., Baltimore, Md.
Hinkle, David O., M.D., Topeka, Kans.
Hoeper, Edwin W., M.D., Marshfield, Wis.
Hoffman, Richard A., M.D., Littleton, Colo.
Hunter, Wallace C., M.D., Houston, Tex.
Ilfeld, Frederic W., Jr., M.D., Sacramento, Calif.
Ives, John O., M.D., North Ferrisburg, Vt.
Johnson, Noel M., M.D., Ft. Wayne, Ind.
Kantar, William G., M.D., Newton, Mass.
Katz, Harry, M.D., Paterson, N.J.
Kazlauskas, Albert J., M.D., St. Clair, Pa.
Kessler, David R., M.D., San Francisco, Calif.
Kinney, Taz W., M.D., Burbank, Calif.
Kinzie, J. David, M.D., Honolulu, Hawaii
Kirts, Thomas E., M.D., DeKalb, Ill.
Kitchen, Alice D., M.D., St. Louis, Mo.
Klausner, Edmond S., M.D., New York, N.Y.
Knopf, Edwin R., M.D., Chalfont, Pa.
LaKosky, Randall A., M.D., St. Paul, Minn.

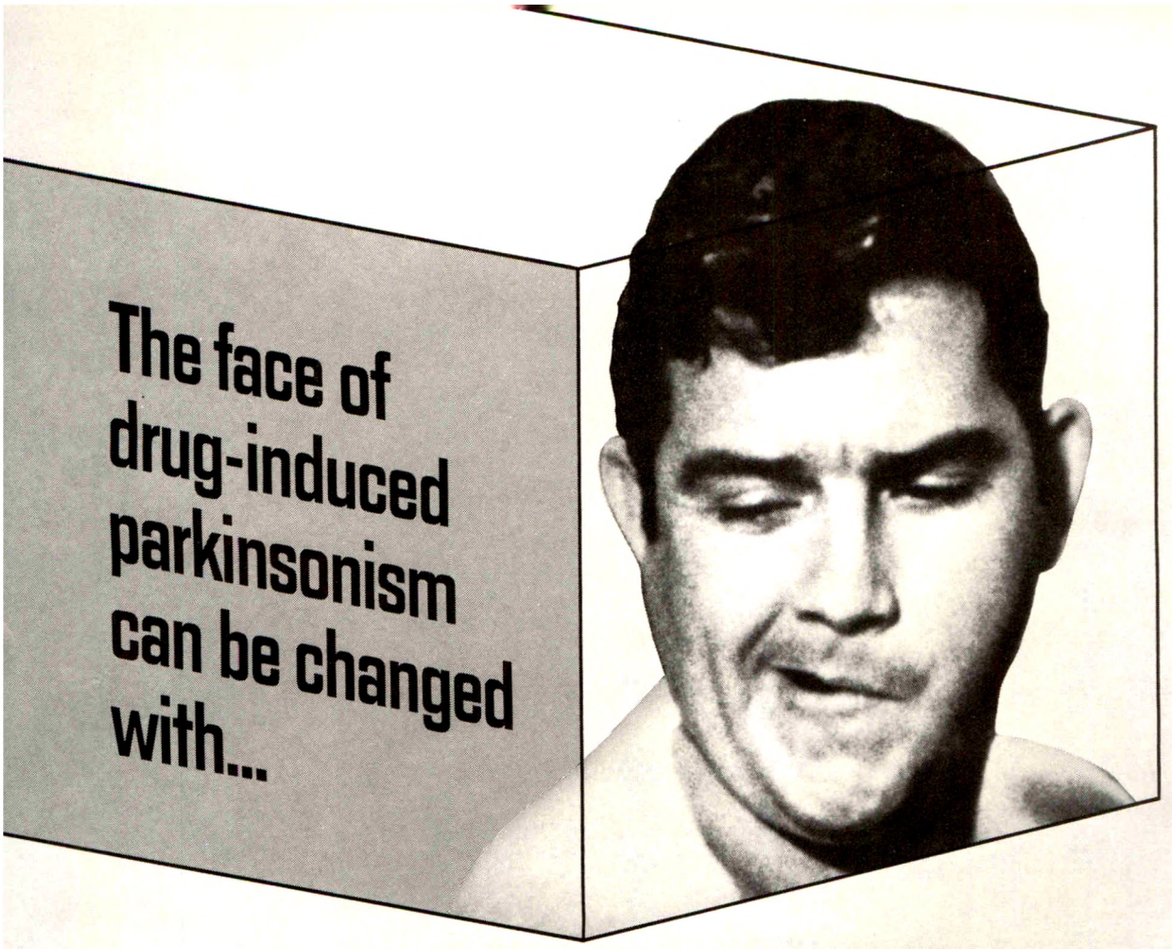
Lee, Sung H., M.D., Dayton, Ohio
Levie, Charles A., M.D., Solana Beach, Calif.
Levine, Matthew E., M.D., Needham, Mass.
Levitis, Gerald M., M.D., Bethesda, Md.
Levy, Florence, M.D., New Haven, Conn.
Liebmann, Karl-O., M.D., Bradford, Conn.
Lilienfeld, Semon M., M.D., Chestnut Hill, Mass.
Lind, Dennis B., M.D., Aiea, Hawaii
Lipkin, John O., M.D., Portland, Ore.
Lipsius, Steven H., M.D., Potomac, Md.
Ludden, John M., M.D., Boston, Mass.
MacKinnon, Bernard L., M.D., Yarmouth, Me.
Magder, Davis M., M.D., Hamilton, Ont., Canada
Makman, Marianne W., M.D., Larchmont, N.Y.
Mattson, Roger A., M.D., Duluth, Minn.
McNeal, Lynnette H., M.D., Norristown, Pa.
Miller, Chester O., M.D., Decatur, Ga.
Morrill, Richard G., M.D., Boston, Mass.
Moss, Seymour R., M.D., Portland, Ore.
Munk, Barbara D., M.D., New York, N.Y.
Murphy, Alvin E., Jr., M.D., Newton, Mass.
Nathan, Habib, M.D., San Antonio, Tex.
Nelson, John F., M.D., Gainesville, Fla.
Nelson, Kenneth E., M.D., San Francisco, Calif.
Norton, Charles B., Jr., M.D., Durham, N.C.
O'Connell, Patrick F., M.D., Gulf Breeze, Fla.
Olenik, Davis A., M.D., Solana Beach, Calif.
Oshrin, Harvey W., M.D., Patton, Calif.
Parwatikar, Sadashiv D., M.D., Olivette, Mo.
Perlman, Michael S., M.D., Longmeadow, Mass.
Pomerantz, Jay M., M.D., Springfield, Mass.
Pronko, Michael, M.D., Prairie Village, Kans.
Ratner, Richard A., M.D., Washington, D.C.
Ray, Ritz C., Jr., M.D., Winston-Salem, N.C.
Ritter, Robert M., M.D., Whitfield, Miss.
Rivera-Nieves, Pedro, M.D., Hato Rey, Puerto Rico
Roberts, Margaret A., M.D., Ann Arbor, Mich.
Rofman, Ethan S., M.D., Boston, Mass.
Rosenbaum, Maj-Britt T., M.D., Larchmont, N.Y.
Rubenfaer, Leon M., M.D., Detroit, Mich.
Rumbaut, Ruben D., Houston, Tex.
Rusk, John M., M.D., Ardmore, Pa.
Ryals, Jarvis D., M.D., Birmingham, Ala.
Ryder, Geoffrey C., M.D., Rockville, Md.
Sanders, Russell W., M.D., Los Angeles, Calif.
Sapoznikoff, John B., M.D., Panama City, Fla.
Satin, Davis G., M.D., Newton Center, Mass.
Schuman, Daniel C., M.D., Wellesley, Mass.
Schuster, Timothy S., M.D., Albuquerque, N. Mex.
Sebastian, Joseph A., M.D., Falls Church, Va.
Secunda, Steven K., M.D., Wallingford, Pa.
Shafer, Roger D., M.D., Los Angeles, Calif.
Sheftell, Fred D., M.D., Stamford, Conn.
Siegel, Allen M., M.D., Chicago, Ill.
Simring, Steven S., M.D., APO New York
Sinha, Ranjit, M.D., Dartmouth, N.S., Canada
Solomon, Fredric, M.D., Washington, D.C.
Spitz, Henry I., M.D., New York, N.Y.
Steele, Thomas E., M.D., New Haven, Conn.
Steury, Steven, M.D., Bethesda, Md.
Stevenson, Karl W., M.D., Durham, N.C.
Stewart, Paul N., M.D., Indianapolis, Ind.
Stillman, Richard C., M.D., Silver Spring, Md.
Stock, Howard F., M.D., Scarsdale, N.Y.
Stubbs, E. Gene, M.D., Portland, Ore.
Swaback, Dwight O., M.D., Sacramento, Calif.
Thrasher, James W., M.D., Woodbury Heights, N.J.
Trott, Thomas F., M.D., Los Angeles, Calif.
Tucker, William A., Jr., M.D., Auburn, N.Y.
Turco, Ronald, M.D., Hagerstown, Md.
Turns, Danielle M., M.D., Poughkeepsie, N.Y.
Varner, Roy V., M.D., Houston, Tex.
Wadsworth, John M., M.D., Montezuma, Colo.
Weinstein, Norman W., M.D., Winter Park, Fla.
Welch, John G., M.D., Brooklyn, N.Y.
Wellborn, Walter H., Jr., M.D., Tarpon Springs, Fla.
Wolin, Steven J., M.D., Washington, D.C.
Woolson, Allen M., M.D., Dearborn, Mich.
Wreggit, John D., M.D., Anchorage, Alaska
Wright, Lawrence A., M.D., Pittsburgh, Pa.
Zall, Harry, M.D., Los Angeles, Calif.
Zinn, Edward, M.D., McLean, Va.

NEUROLOGY

Ackerman, Robert H., M.D., Boston, Mass.
Aldredge, Horatio R., M.D., San Antonio, Tex.
Bercaw, Beauregard L., M.D., Largo, Fla.
Birbiglia, Vincent P., M.D., Northboro, Mass.
Birnbaum, Gary, M.D., New York, N.Y.
Brennan, Robert W., M.D., Hershey, Pa.
Calabrese, Vincent P., M.D., Richmond, Va.
Coatsworth, James J., M.D., Seattle, Wash.
Curtin, William J., M.D., Modesto, Calif.
Dowling, Peter C., M.D., Bronx, N.Y.
Embree, Larry J., M.D., Lexington, Mass.
Ertag, William D., M.D., West Orange, N.J.
Ferrendelli, James A., M.D., St. Louis, Mo.
Garcia-Mullin, Ricardo G., M.D., Miami Beach, Fla.
Geiger, Leonard R., M.D., Villanova, Pa.
Heilman, Kenneth M., M.D., Gainesville, Fla.
Herman, Martin N., M.D., Westfield, N.J.
Hussey, Francis D., Jr., M.D., Naples, Fla.
Hyman, Paul R., M.D., Columbus, Ohio
Jacobs, Lawrence D., M.D., Larchmont, N.Y.
Leschey, William H., M.D., Portland, Me.
Librot, Irwin E., M.D., New City, N.Y.
Lipton, Howard L., M.D., Chicago, Ill.
Maier, Rudolph J., M.D., Albuquerque, N. Mex.
Markand, Omkar N., M.D., Indianapolis, Ind.
Markesbery, William R., M.D., Lexington, Ky.
Menzer, Leon, M.D., Norwood, Mass.
Morley, Gerald K., M.D., Minneapolis, Minn.
Mortati, Frederick S., M.D., Dix Hills, N.Y.
Newton, Charles T., M.D., Pillsford, N.Y.
Ng, Khye W., M.D., Durham, N.C.
Nusbaum, Edward D., M.D., Minot, N. Dak.
Raichle, Marcus E., M.D., St. Louis, Mo.
Rapoport, Alan M., M.D., Stamford, Conn.
Scales, David F., Jr., M.D., Jacksonville, Fla.
Scheinblum, Allan F., M.D., Hollywood, Fla.
Shanawani, Mohamed S., M.D., Orange, N.J.
Sherman, Robert, M.D., Mineola, N.Y.
Sun, Sallie F., M.D., Washington, D.C.
Sweet, Richard D., M.D., Scarsdale, N.Y.
Tsairis, Peter, M.D., New York, N.Y.
Wasserman, Michael J., M.D., Hinsdale, Ill.
Waxman, Jordan D., M.D., Deerfield, Ill.
Weir, Roger L., M.D., Washington, D.C.
Wolfson, Leslie I., M.D., Hartsdale, N.Y.

CHILD NEUROLOGY

Gabriel, Ronald S., M.D., Los Angeles, Calif.
Leider, William B., M.D., San Francisco, Calif.
Russman, Barry S., M.D., Glastonbury, Conn.
Sieben, Robert L., M.D., Lafayette, Calif.

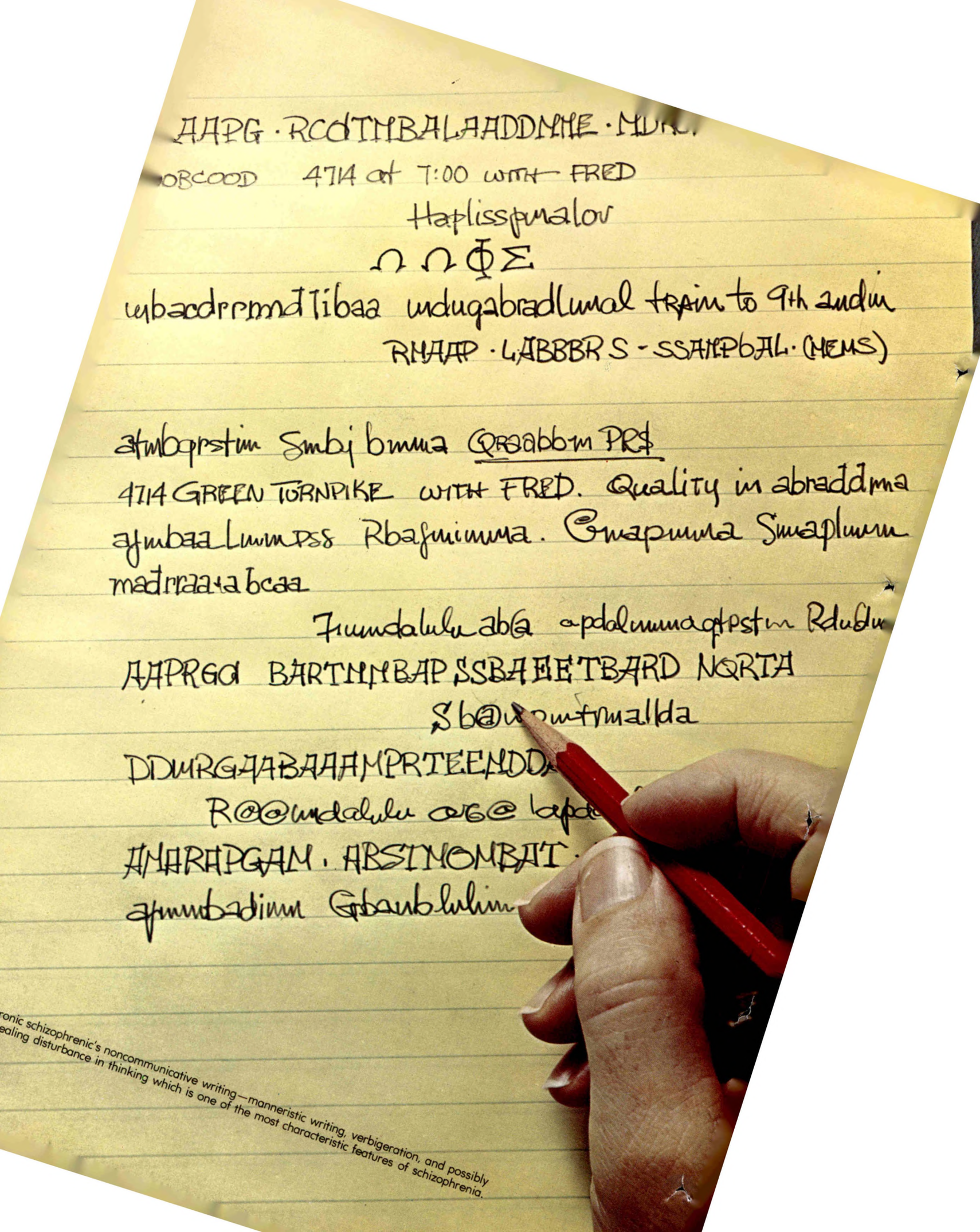


AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

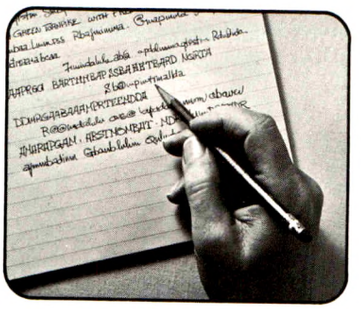
WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally; **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA



ronic schizophrenic's noncommunicative writing—manneristic writing, verbigeration, and possibly
ealing disturbance in thinking which is one of the most characteristic features of schizophrenia.


Unusual thought content...
a target symptom in schizophrenia that responds particularly well to treatment with SERENTIL®
(mesoridazine)
Tablets, 50 mg. (as the besylate)
The disturbances in thinking and conceptualization that are most characteristic of schizophrenia are particularly responsive to treatment with Serentil. Symptoms of unusual thought content, conceptual disorganization, and hallucinatory behavior—whatever their degree of severity—are potentially reversible.
Serentil is effective in both acute and chronic forms of schizophrenia. Serentil Tablets and Concentrate provide dosage flexibility for initiating and maintaining therapy for both hospitalized and discharged patients.
The injectable form of Serentil is especially valuable for efficient management of symptoms in many newly admitted patients and for rapid control of acute episodes in office practice.
For brief summary, please see following page.
SANDOZ
73-731

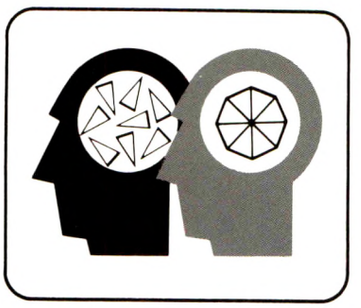


Unusual thought content...

a target symptom in schizophrenia that responds particularly well to treatment with

SERENTIL®
(mesoridazine)

Tablets, 50 mg. (as the besylate)



Contraindications: Severe central nervous system depression, comatose states, hypersensitivity.

Warnings: Increase dosage gradually to patients participating in activities requiring complete mental alertness (e.g., driving). The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus. Use in children under 12 is not recommended. Phenothiazines are capable of potentiating central nervous system depressants as well as atropine and phosphorus insecticides.

Precautions: Ocular changes (seen with other phenothiazines) have not been seen with Serentil (mesoridazine). Because of possible hypotensive reactions, caution in parenteral use is required. Reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection. Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. Blood dyscrasia (seen with other phenothiazines) has occurred in a single case of transient granulocytopenia.

Adverse Reactions: Serentil (mesoridazine) has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds. *Central Nervous System:* Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos). *Autonomic Nervous System:* Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision. *Endocrine System:* Inhibition of ejaculation and lactation have been noted rarely. *Skin:* Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema. *Cardiovascular System:* Hypotension, tachycardia, EKG changes. The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Serentil (mesoridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. There is no evidence that these changes are precursors of any significant disturbance of cardiac rhythm. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, and akinesia, occasionally persisting for several months or years especially in elderly patients with brain damage. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, weight gain, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia, behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

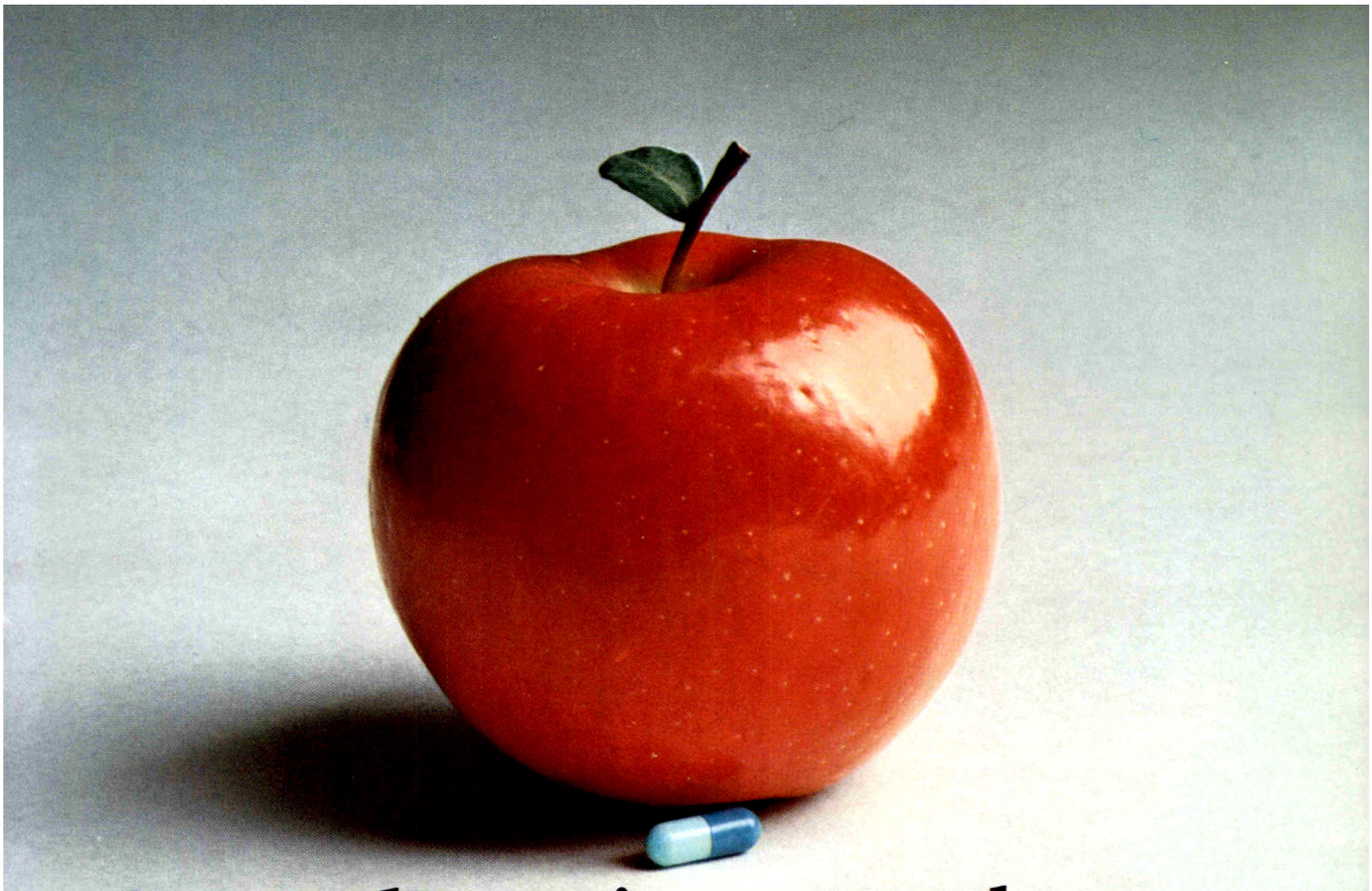
Dosage and Administration: ORAL: Should be adjusted to needs of the individual. Lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to maintenance level. *Schizophrenia:* For most patients, regardless of severity, starting dose of 50 mg. t.i.d. recommended. Usual optimum total daily dose range 100-400 mg. *Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome:* For most patients starting dose of 25 mg. t.i.d. recommended. Usual optimum total daily dose range 75-300 mg. *Alcoholism:* For most patients usual starting dose is 25 mg. b.i.d. Usual optimum total daily dose range 50-200 mg. *Psychoneurotic Manifestations:* For most patients usual starting dose is 10 mg. t.i.d. Usual optimum total daily dose range 30-150 mg. INJECTABLE FORM: For situations in which an intramuscular form of medication is indicated. For most patients a starting dose of 25 mg. is recommended, to be repeated in 30-60 minutes if necessary. Usual optimum total daily dose range 25-200 mg.

73-731

Before prescribing, consult package circular.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936

SANDOZ



Once-a-day maintenance therapy. Introducing New Navane® 20 mg. (thiothixene) capsules

Once-a-day maintenance...

Once you've controlled acute psychosis or psychotic depression with a t.i.d. regimen, some patients can be maintained on one new Navane 20 mg. capsule a day. And for patients requiring higher dosages, two or three capsules, once a day, may be sufficient. This once-a-day regimen can reduce the risk of missed doses, with no loss of efficacy.

Once-a-day efficacy...

A recent double-blind, crossover study[1] compared Navane capsules, t.i.d., with an equivalent-dose once-a-day regimen. Both groups had statistically equivalent, significant clinical improvement over baseline at the end of the study period. And although the difference in extrapyramidal side effects was not statistically significant, the once-a-day group had a lower score.

Once-a-day economy...

For inpatient therapy, once-a-day Navane capsules can provide a saving of valuable nursing time. And for both institutions and outpatients, the 20-mg. capsule has another economy advantage: it's less costly than two 10-mg. or four 5-mg. capsules.

Navane 20-mg. It's a new dosage strength to maintain control of psychotic behavior. Effectively. Conveniently. And economically.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

1. Data on file, Roerig.

For prescribing information, including adverse reactions and contraindications, please see following page of this advertisement.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg., 2 mg., 5 mg., 10 mg., 20 mg.

Concentrate: 5 mg./cc.
Intramuscular: 2 mg./cc.

PRESCRIBING INFORMATION
Navane® (thiothixene)
Capsules 1 mg., 2 mg., 5 mg., 10 mg., 20 mg. (thiothixene hydrochloride)
Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane (thiothixene), there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg./kg./day), rabbits (3 to 50 mg./kg./day), and monkeys (1 to 3 mg./kg./day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane (thiothixene) may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane [thiothixene] for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis), have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration – As with all intramuscular preparations, Navane (thiothixene hydrochloride) Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the midlateral thigh.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower- and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following reactions have been reported with Navane. However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane (thiothixene) is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur, although it usually subsides with continuation of Navane therapy. The incidence of sedation appears to be similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudoparkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: Although not reported with Navane, certain antipsychotic agents have been associated with persistent dyskinesias. Tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leucocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration because safe conditions for its use have not been established.

Dosage and Administration. Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Usage in children under 12 years of age is not recommended.

Navane Intramuscular Solution—For Intramuscular Use Only. Where more rapid control and treatment of behavior is desirable, the intramuscular form of Navane (thiothixene hydrochloride) may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg. of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg./day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg. three times daily. If indicated, a subsequent increase to 15 mg./day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg. twice daily.

The usual optimal dose is 20 to 30 mg. daily. If indicated, an increase to 60 mg./day total daily dose is often effective. Exceeding a total daily dose of 60 mg. rarely increases the beneficial response.

Some patients have been successfully maintained on once-a-day Navane (thiothixene) therapy.

Overdosage. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, disturbances of gait, or coma.

Treatment: Essentially symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Picrotoxin or pentylenetetrazol should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

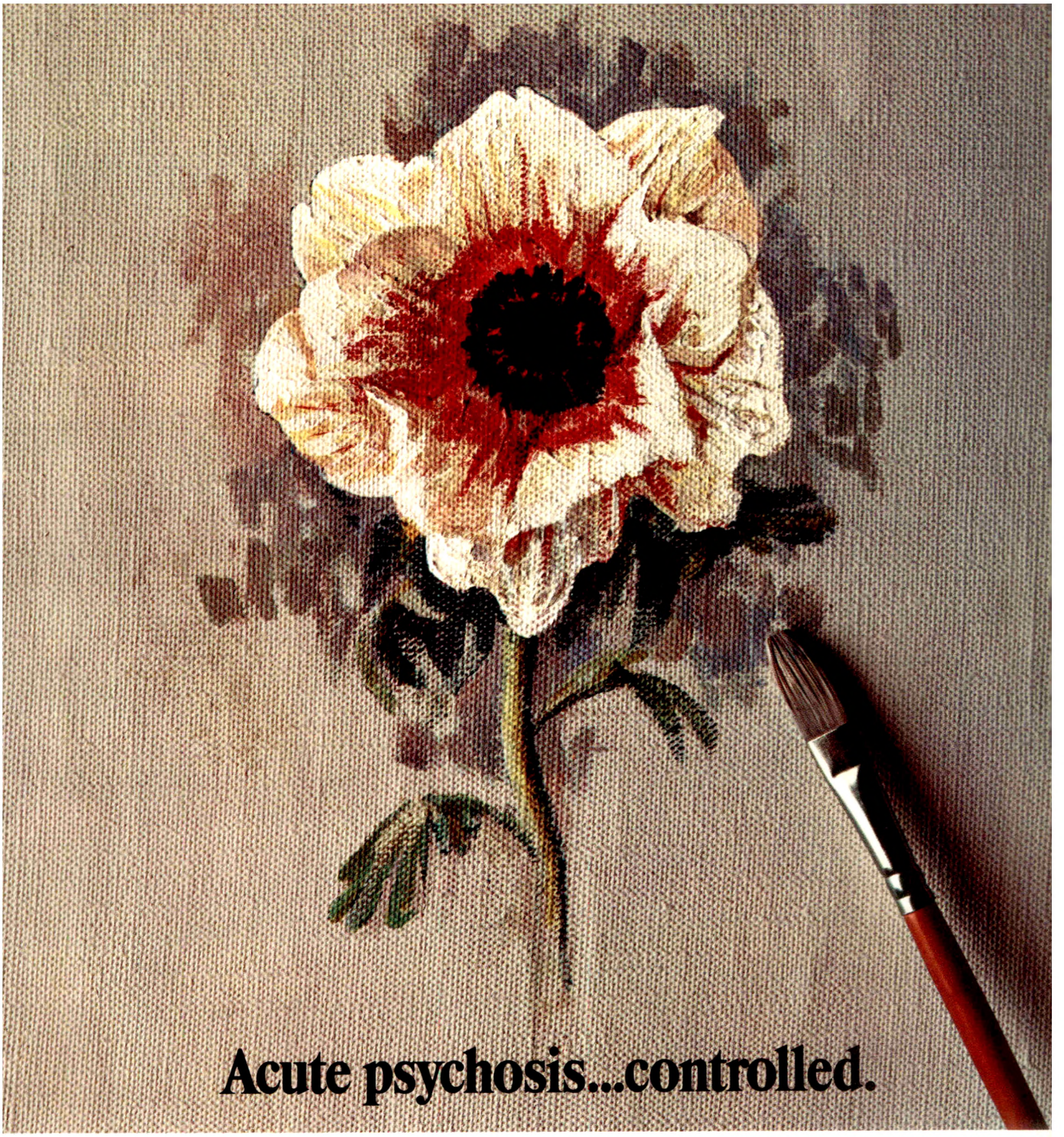
There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is available as capsules containing 1 mg., 2 mg., 5 mg., and 10 mg. in bottles of 100 and 1,000. Navane is also available as capsules containing 20 mg. of thiothixene, in bottles of 100 and 500.

Navane (thiothixene hydrochloride) Concentrate is available in 120 cc. (4 oz.) bottles with an accompanying dropper calibrated at 2 mg., 4 mg., 5 mg., 6 mg., 8 mg. and 10 mg. Each cc. contains thiothixene hydrochloride equivalent to 5 mg. of thiothixene. Contains alcohol, U.S.P. 7.0% v/v. (small loss unavoidable).

Navane (thiothixene hydrochloride) Intramuscular Solution is available in a 2 cc. amber glass vial in packages of 10. Each cc. contains thiothixene hydrochloride equivalent to 2 mg. of thiothixene, dextrose 5% w/v, benzyl alcohol 0.9% w/v.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



Navane (thiothixene) helps reduce the intensity and frequency of acute psychotic symptoms. With Navane, confusion, disorientation and other manifestations of acute psychosis may be controlled. And, as acute symptomatology decreases, the patient may be better able to readjust to therapeutic, family and community relationships and responsibilities. Navane...an effective anti-psychotic for acute psychosis.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Navane®

(thiothixene) (thiothixene hydrochloride)

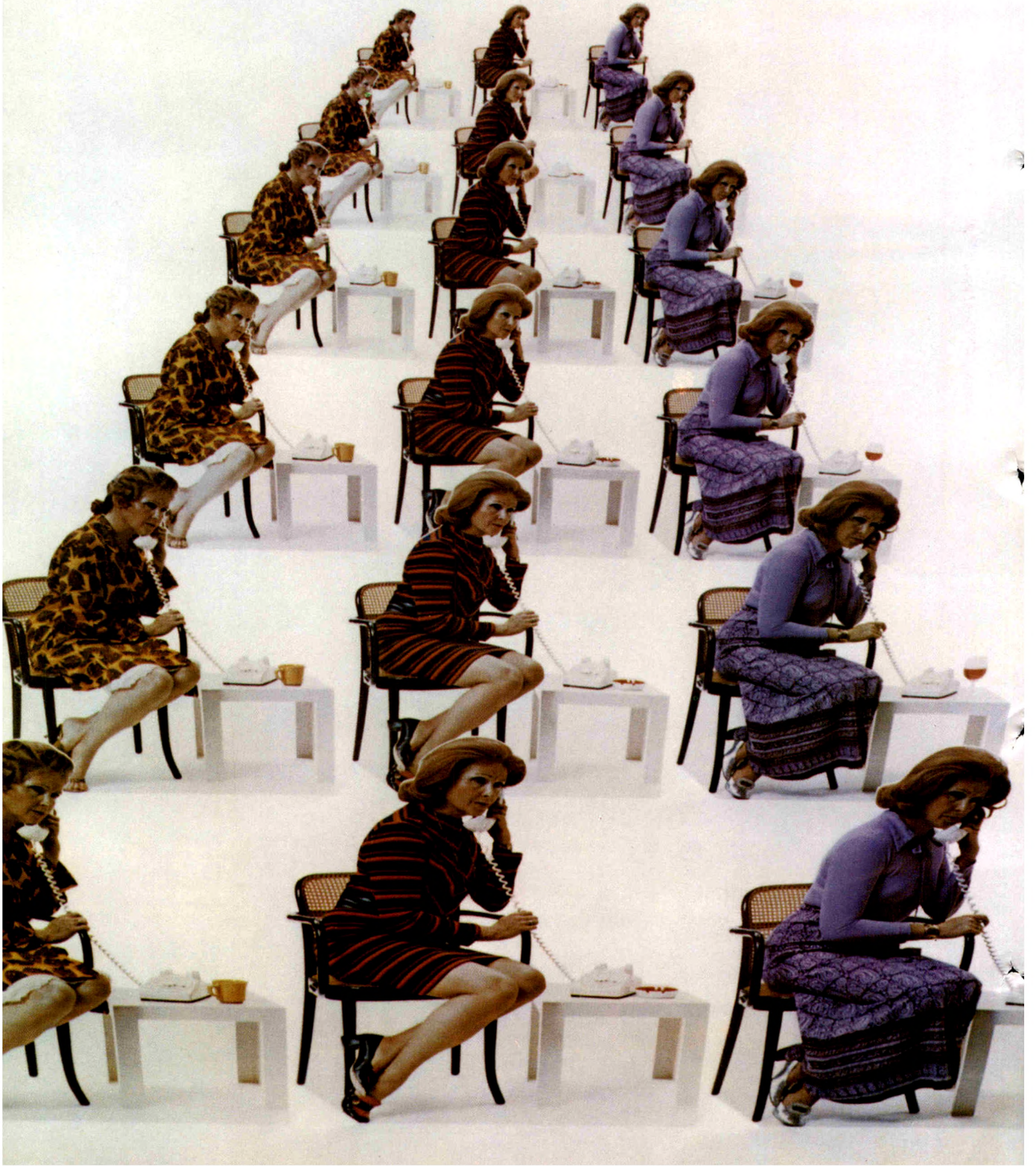
Capsules 1 mg., 2 mg., 5 mg., 10 mg. Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

to help control psychotic behavior

For prescribing information, including adverse reactions and contraindications, please see facing page of this advertisement.

If she calls you morning...noon...and night

day after day after day



To allay her chronic neurotic anxiety* try her on

Stelazine®

brand of **trifluoperazine HCl 2 mg. tablets**

Excessive use of the telephone is often symptomatic of chronic neurotic anxiety. Because such patients are often immune to lasting reassurance, in addition to your counsel, supportive medication may be helpful.

For such patients, 'Stelazine' is often a wise choice. Its anti-anxiety action is usually free from excessive drowsiness. The recommended b.i.d. dosage is convenient and economical. And dependence and withdrawal symptoms have not been reported with 'Stelazine' therapy.

* 'Stelazine' has been evaluated as possibly effective for this indication. See Brief Summary.

Before prescribing, see complete prescribing information, including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

* **Indications**

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, pancytopenia, anemia, cholestatic jaundice, liver damage have been reported.

Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 1 mg., 2 mg., 5 mg. and 10 mg., in bottles of 100; Injection, 2 mg./ml.; and Concentrate, 10 mg./ml.

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630, under Stelazine® trademark license from SmithKline Corporation, Philadelphia, Pa.

The challenge: versatility

The stereotype image of "psychiatrist and couch" is an anachronism because today's psychiatrist is called on to diagnose and treat depression in a variety of clinical settings. And when an antidepressant medication is chosen, it must be as flexible and as adaptable as the physician prescribing it.



The psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL® (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations.

The general hospital today usually provides a psychiatric unit where depressed patients are treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic, where follow-up treatment may be necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital, severely depressed patients present challenges for psychiatrist and staff alike. Here, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



The community mental health center, a remarkable innovation in the field of modern psychiatry, offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

in the treatment of depression

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps open many doors

For a brief summary of prescribing information, please see following page.

MSD
MERCK
SHARP &
DOHME

addendum

ELAVIL®
(AMITRIPTYLINE HCl | MSD)
dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for most outpatients, who generally do well on 25 mg three times a day. This dosage may be increased to a total of 150 mg a day. Dosage increases are made preferably in the late afternoon or at bedtime. The sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be indicated whenever higher dosages are required, as for example when increases are necessary in the late afternoon or bedtime doses. It may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher dosages.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: The intravenous administration of 1–3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

in the treatment of depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)
helps open many doors

mirror, mirror on the wall, can this hospitalized schizophrenic relate to herself at all?





If the answer is "yes,"

then she can be helped to relate to others with the adjunctive use of

Trilafon®

brand of
perphenazine, NF

TRILAFON®
brand of perphenazine, NF
Tablets
REPETABS® Tablets
Syrup Concentrate Injection

CONTRAINDICATIONS TRILAFON is contraindicated in drug-associated central nervous system depression (barbiturates, alcohol, narcotics, analgesics, antihistamines). Perphenazine is contraindicated in the presence of existing blood dyscrasias, bone marrow depression and pre-existing liver damage, and in patients who are hypersensitive to perphenazine.

TRILAFON Injection should not be given to patients in coma or severely depressed states.

WARNINGS Usage in pregnancy: Perphenazine should only be given to pregnant patients when, in the judgment of the physician, the potential benefits outweigh the possible risks.

Perphenazine can lower the convulsive threshold in susceptible individuals; it should be used with caution in patients with convulsive disorders. If the patient is being treated with an anticonvulsant agent, increased dosage of that agent may be required when perphenazine is used concomitantly.

Perphenazine should be used with caution in patients with psychic depression.

Perphenazine is not recommended for children under 12 years of age.

Perphenazine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery.

PRECAUTIONS As with any potent medication, patients receiving perphenazine should be under medical supervision, particularly if they are receiving high doses. Patients who have had any severe reaction to phenothiazines or to imipramine should be treated cautiously, under close medical supervision.

Although the following adverse reactions have not been reported in patients treated with perphenazine, the possibility that they might occur with TRILAFON should be considered; blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, eosinophilia); liver damage (biliary stasis); narrowing of the visual fields; pigmentation of the retina, cornea, or lens; cerebral edema; polyphagia; photophobia; hyperpyrexia.

If hypotension develops, levarterenol (norepinephrine) can be used, but not epinephrine, because epinephrine's action is blocked and partly reversed by perphenazine. Severe, acute hypotension has occurred with the use of phenothiazines and is of particular concern in patients with mitral insufficiency or pheochromocytoma.

A significant rise in body temperature may indicate an idiosyncratic reaction to perphenazine; treatment with perphenazine should be stopped if this occurs.

The antiemetic effect of perphenazine can obscure signs of toxicity due to overdosage of other drugs, or mask the symptoms of disease (eg, brain tumor or intestinal obstruction).

Contact dermatitis has been reported with a perphenazine solution; therefore, contact of hands or clothing by those handling perphenazine solutions should be avoided.

POTENTIATION Since phenothiazines can potentiate the central-nervous-system-depressant actions of opiates, antihistamines, barbiturates, and alcohol, less

Schering

Tablets 2,4,8,16 mg. REPETABS® 8 mg.	for maintenance therapy with cooperative patients
Concentrate 16 mg./5 cc. 4 oz. bottle with calibrated dropper	for "cheeking," geriatric, confused or otherwise untrustworthy psychotic patients
Injection 5 mg./cc., 10 cc. multiple-dose vial, 1 cc. ampule	for emergency or initial treatment of agitated psychotics



A potent phenothiazine to help:

- maintain alertness level
- stabilize behavioral patterns
- relieve anxiety/agitation
- increase patient response to psychotherapy

Trilafon®

brand of

perphenazine, NF

a major tranquilizer for in-hospital control and take-home therapy

---

n the usual dosage of these agents is required when they are administered comitantly with TRILAFON. Patients should be cautioned that their response lcohol may be increased while they are being treated with TRILAFON.
henothiazines also potentiate the effects of atropine, heat, and phosphorus ecticides, and should be used with caution in persons exposed to these agents.

ERSE REACTIONS *Extrapyramidal reactions:* dystonia including protru-, discoloration, aching and rounding of the tongue; tonic spasm of the mas-tory muscles, tight feeling in the throat, slurred speech, dysphagia, oculogyric is, trismus, torticollis, retrocollis, muscle weakness, and aching and numb- of the limbs; akathisia; motor restlessness; dyskinesia, parkinsonism; erreflexia; and ataxia. The incidence and severity of these reactions usually ease with increased dosage, but have occurred in some patients receiving dosage. Reduction in dosage or treatment with an antispasmodic agent will ally control extrapyramidal reactions. In some instances, however, these tions may persist after discontinuation of treatment with perphenazine.
ersistent tardive dyskinesia: As with all antipsychotic agents, tardive dys-sia may appear in some patients on long-term therapy or may appear after therapy has been discontinued. The risk appears to be greater in elderly ents on high-dose therapy, especially females. The symptoms are persistent in some patients appear to be irreversible. The syndrome is characterized by hmical involuntary movements of the tongue, face, mouth or jaw (eg, pro-ion of tongue, puffing of cheeks, puckering of mouth, chewing movements). etimes these may be accompanied by involuntary movements of extremities. e is no known effective treatment for tardive dyskinesia; antiparkinsonism nts usually do not alleviate the symptoms of this syndrome. It is suggested all antipsychotic agents be discontinued if these symptoms appear. Should e necessary to reinstitute treatment, or increase the dosage of the agent, or ch to a different antipsychotic agent, the syndrome may be masked. It has n reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Allergic reactions: erythema, pruritus, urticaria, eczema, anaphylactoid reactions, and local and generalized edema. In extremely rare instances, individual idiosyncrasy or hypersensitivity to phenothiazines has resulted in cerebral edema, circulatory collapse, and death. Photosensitization, asthma, and exfoliative dermatitis have also occurred in patients treated with phenothiazines.

Autonomic reactions: blurred vision, dry mouth or salivation, nasal congestion, nausea, vomiting, hypertension, tachycardia, hypotension, anorexia, urinary frequency or incontinence, and constipation. Significant autonomic effects have been infrequent in patients receiving less than 24 mg. perphenazine daily.

Other reactions: endocrine disturbances (lactation, gynecomastia, galactorrhea, disturbances in the menstrual cycle), headaches, mild insomnia, altered cerebrospinal fluid proteins, ECG abnormalities, reactivation of psychosis, paradoxical excitement, paranoid-like reactions, catatonia, and systemic lupus erythematosus-like syndrome. Hypnotic effects appear to be minimal, particularly in patients who are permitted to remain active. The following adverse reactions, though rare, have also been reported to be associated with perphenazine treatment: agranulocytosis; jaundice; hyperpigmentation of the skin; grand mal convulsions; failure of ejaculation; hyperglycemia.

Side effects with intramuscular TRILAFON Injection have been infrequent and transient. Dizziness or significant hypotension after treatment with TRILAFON Injection is a rare occurrence.

NOVEMBER 1972

Schering

Schering Corporation, Bloomfield, N.J. 07003

SWW-270

TASK FORCE REPORT 4

COMMUNITY MENTAL HEALTH CENTERS

- puts the Center movement in historical perspective and describes its relationship to the state hospitals, general health programs, the communities served, and to private practitioners.
- elaborates on the relationship of psychiatrists in the Centers to other professionals and non professionals.
- poses issues for medical and psychiatric education.
- contains APA's official position statement on Center development.

29 pages $1.75

(6-10 copies, $1.50 ea.; 11-20 copies, $1.20 ea.; Bulk prices on request.)

Please send me _____ copy(ies) of ***Task Force Report 4, Community Mental Health Centers,*** order #185, @ 1-5 copies, $1.75 ea.; 6-10 copies, $1.50 ea.; 11-20 copies, $1.20 ea.; Bulk prices on request.

☐ Bill Me ☐ Check Enclosed

(Please Print)

Name _____

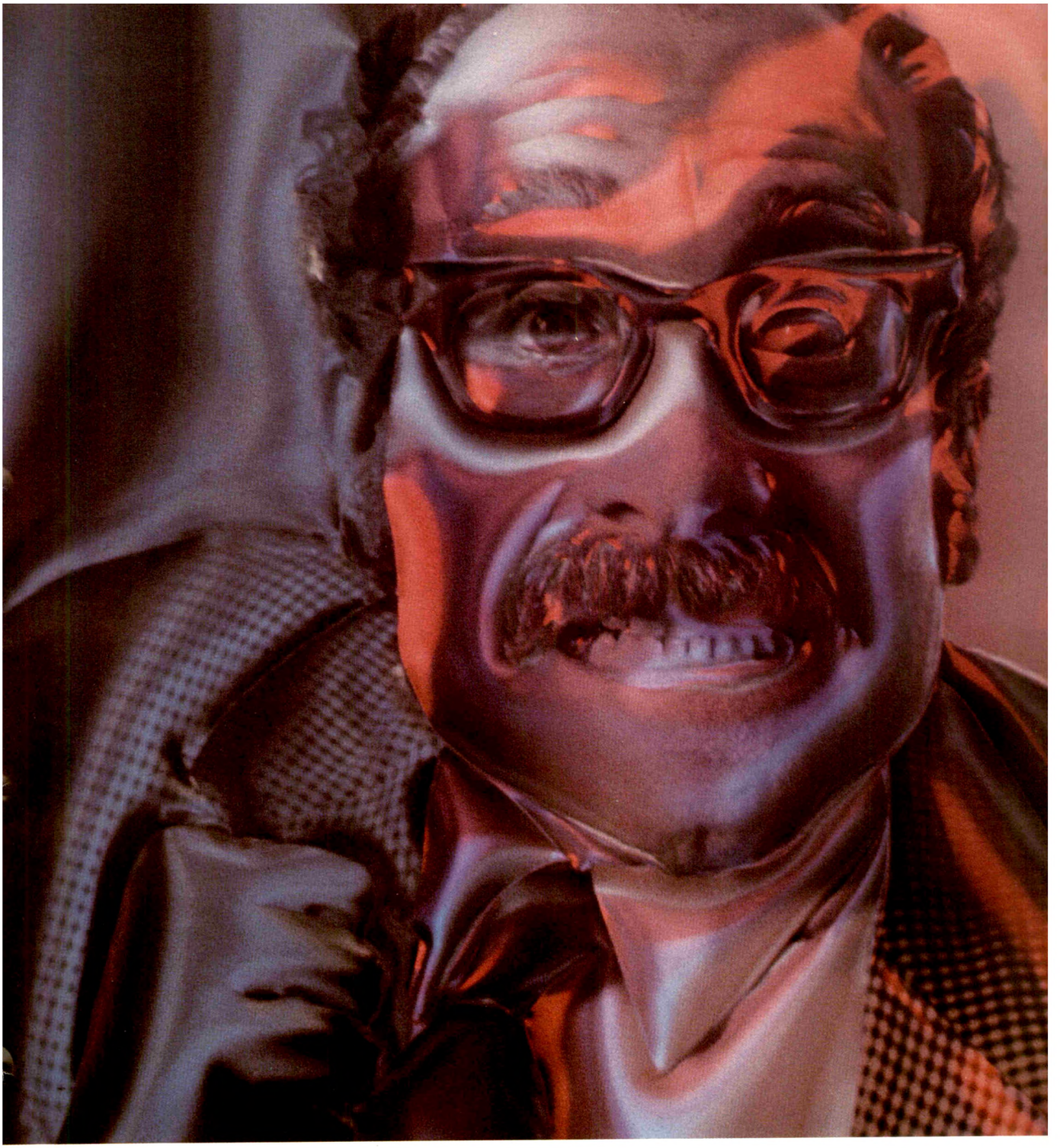
Address _____

City _____ State _____ Zip _____

Send Coupon to:

American Psychiatric Association
Publications Sales
1700 Eighteenth St. N.W.
Washington, D.C. 20009

773AJP



Agitated and hyperactive?...Or cooperative?

While psychotic symptoms remain acute, the barrier between you and the agitated, hyperactive patient may be insurmountable. Prompt intervention with HALDOL (haloperidol) often makes it possible for you to reach... relate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

cooperation often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

© MCNEIL LABORATORIES, INC., 1973

Haldol®
(HALOPERIDOL)

a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: For the treatment of such symptoms as moderate to severe agitation, anxiety and tension, assaultiveness, delusions, hallucinations, hostility, and hyperactivity when they are manifestations of psychosis including schizophrenia, the manic type of manic depressive illness, or psychotic reactions associated with organic brain syndromes or mental retardation. For the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy***—Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children—Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General—Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold, although it will *not* increase the effects of anticonvulsant medication. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 11/72

McNEIL
McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models– **PORTABLE FOR OFFICE AND CLINIC**



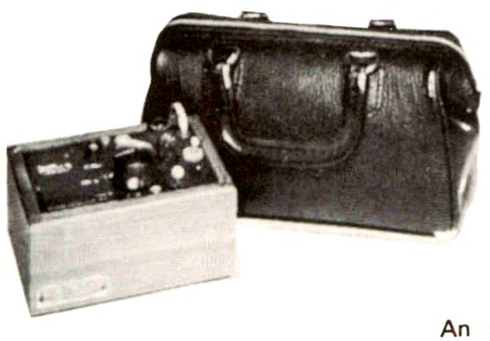
The Reiter MODEL SOS–THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives–patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes –a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211

Three new JIS publications:

THE TREATMENT OF DRUG ABUSE — Programs, Problems, Prospects

AUTHORS: Raymond Glasscote, Jerome H. Jaffe, James N. Sussex, John Ball, Leon Brill

What can a community that wants to do something about a perceived drug abuse problem reasonably expect to get for its efforts? That is the question the authors undertook to answer through a field study that consisted of visits to nine programs operating more than forty facilities and components for various categories of persons who use drugs — mainly narcotics. They conclude that no single one of the presently available approaches can be expected to be successful with more than a small percentage of the drug-abusing population, and all approaches combined will have an "undoubtedly limited" effect. Rather than take a position for or against any particular treatment approach, they discuss the positive and negative features of each. A wealth of significant detail is provided about a number of well-known programs, with an objectivity that has been altogether too rare in this field. The authors set forth one reasonable sequence that might be followed by communities seeking to establish various drug treatment resources that will be appropriate for their particular needs.

250 pages

$7.00

CHILDREN AND MENTAL HEALTH CENTERS — Programs, Problems, Prospects

AUTHORS: Raymond Glasscote, Michael Fishman, Meyer Sonis

This tenth in a series of Joint Information Service field studies of mental health programs focuses on the efforts of federally assisted mental health centers to meet the needs of children and adolescents, both through direct treatment services and through consultation programs that seek to enhance the competence of numerous kinds of persons who have an important influence on the lives of children. Based on visits by the authors and consultants to eight outstanding programs, this volume also incorporates the findings of a questionnaire survey to all federally supported community mental health centers. It also provides a full but concise history of treatment efforts for young people in this country, and, most important, it sets forth a hypothetical comprehensive program that is broader than any single program presently operating in the United States.

257 pages

$7.00

ELEVEN INDICES

PREPARED BY Charles Kanno

This "aid in reviewing state and local mental health and hospital programs" is a successor to the long-established *Fifteen Indices*, published by the Joint Information Service since 1956. The new version eliminates some of the indices that are no longer applicable in view of changes in the mental health delivery system, adds new ones, and uses a different reporting form for others. It provides state-by-state data for expenditures for mental health programs, hospitalization rates, rehabilitated mental illness clients, percent of population living in community mental health center catchment areas, and so on. In addition, a separate profile is provided for each state, indicating its performance against the national averages.

83 pages

$4.00

Published by

The Joint Information Service
of the American Psychiatric Association
and the National Association for Mental Health

Please send me: _____ copy(ies) of *The Treatment of Drug Abuse*, Order #197, @ $7.00 each (casebound)

_____ copy(ies) of *Children and Mental Health Centers*, Order #172, @ $7.00 each (casebound)

_____ copy(ies) of *Eleven Indices*, Order #212, @ $4.00 each (paperbound)

OR _____ ONE COPY EACH OF ALL THREE FOR $15.00.

☐ Bill me ☐ Check enclosed

(PLEASE PRINT)

Name _____

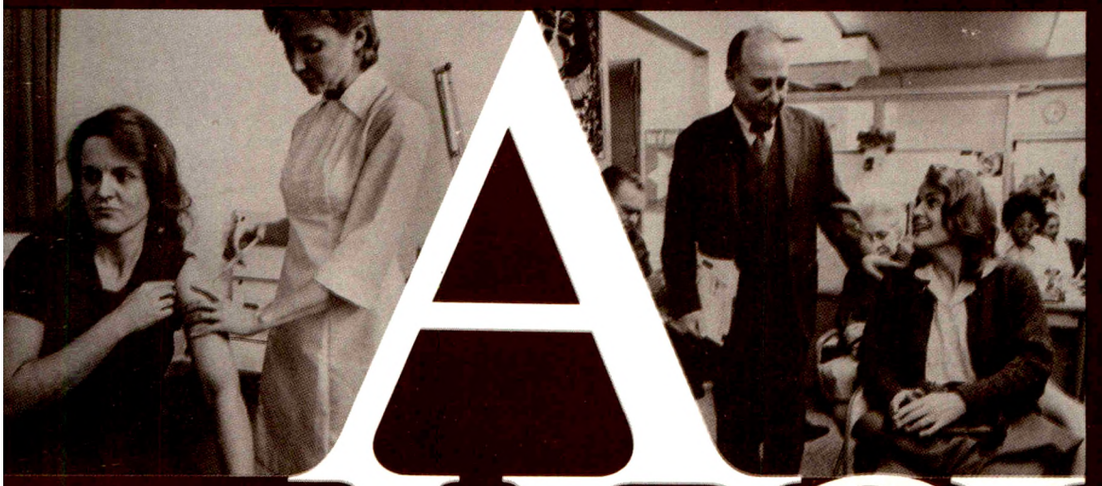
Address _____

City _____ State _____ Zip _____

Send coupon to: **AMERICAN PSYCHIATRIC ASSOCIATION**
Publications Services Division
1700 Eighteenth Street, N.W.
Washington, D.C. 20009

773AJP

For schizophrenic patients...



A way out:



...that helps keep them out

Controlled Drug Delivery

with new

PROLIXIN® DECANOATE

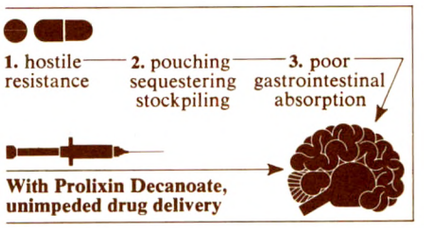
(FLUPHENAZINE DECANOATE INJECTION)

Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer with an average duration of effect of about 2 weeks

Controlled drug delivery — a revolution in patient management

PROLIXIN® DECANOATE (Fluphenazine Decanoate Injection) HELPS ASSURE EFFECTIVE, UNHINDERED MEDICATION

Controlled drug delivery is *physician*-controlled delivery, an effective prophylactic maneuver against disruption of therapy—one of the most common causes of psychotic relapse. Is the patient taking his medication? You know because you administer it or direct others to. Once administered, therapy cannot be altered by the patient, by his family, or by anyone else.



In most patients, symptomatology is controlled by Prolixin Decanoate for periods of two weeks with a single injection. Sequestered medication and similar problems associated with oral therapy are not encountered. Nor does the patient risk drug loss through severe diarrhea or poor gastrointestinal absorption. Prolixin Decanoate keeps the patient medicated...helps make him more amenable to the entire treatment program and improves his chances for rehabilitation and discharge.

The outpatient is vulnerable to the dictates of his own poor judgment. Deluded by a sense of well-being, he may question the need for medication. Family and friends often give him misleading advice. Oral therapy in such a patient encourages missed doses. Medication with Prolixin Decanoate (Fluphenazine Decanoate Injection) helps assure drug delivery when required and in the dosage prescribed. It helps keep the outpatient out.



FOUR REASONS FOR READMISSION...

For brief summary, see last page of this presentation.

OLIXIN® DECANOATE
uphenazine Decanoate Injection)
SURES ECONOMIC DRUG
LIVERY...LESS FREQUENT
)SING THAN WITH ORAL
IERAPY

Controlled drug delivery brings cost therapy down with less hospitaliza-n, less nursing time, less frequent sing. Low annual dosage means less t for the hospital, for the patient's nily, and for the community. It ans a minimum of drug holidays to oid long-term complications, with ir confusing schedules for patient l family.

ntrolled drug delivery—
evolution in the treatment of the izophrenic patient

OLIXIN® DECANOATE
uphenazine Decanoate Injection)
LPS ENHANCE LIKELIHOOD
DISCHARGE

Optimally, the mental hospital ould be a rehabilitating bridge be-een life before and life after custo-al care. Prolixin Decanoate often ortens that bridge because getting the atient out is frequently a matter of eping him medicated. And 1 injec-n of Prolixin Decanoate means ap-oximately 2 weeks of symptom ntrol. The importance of control by physician with this injectable can seen in the fact that about 1 out of ery 5 inpatients does not take his tab-s even when they are administered by nursing staff. With controlled drug delivery, lost or hidden doses are not a problem.

In one study,[1] 24 chronic long-term hospital patients were treated with Prolixin Decanoate in dosages of 12.5 mg. to 75 mg. given every 7 days to 3 weeks. Most of the patients received 25 to 50 mg. per injection. Of these, 13 were discharged after 6 months of treatment, 4 were considered dischargeable, and 7 did not improve. In 12 of the 24 patients who previously had been on different psychotropic drugs for periods of 4 to 96 weeks, improvement with Prolixin Decanoate (Fluphenazine Decanoate Injection) was observed in affect, volition, and higher mental functions. Dischargeability in these patients "may also have been enhanced because the staff, the patient, and the family were assured of an adequate and regular medication intake."[1]

Controlled drug delivery—
a revolution in the care of the outpatient

PROLIXIN® DECANOATE
(Fluphenazine Decanoate Injection)
PROMOTES CONTINUITY OF MEDICATION WITH DIMINISHED LIKELIHOOD OF RELAPSE COMPARED WITH ORAL THERAPY

Success in rehabilitative areas like employment and social acceptance depends in large measure on adequate and continuing phenothiazine intake; success in family adjustment no less so. Short-acting medication is not the best path to such success. According to one report,[2] "approximately 50% of all discharged psychotic patients fail to take even the first dose of their outpatient medication." And McClellan and Cowan[3] state that a substantial number of patients taking antipsychotic drugs do so in amounts significantly less than those prescribed. Even once-daily administration does not solve the problem of poor home supervision or the patient's lack of insight into his condition.

Controlled drug delivery with Prolixin Decanoate (Fluphenazine Decanoate Injection) is an efficient route to continuity of medication, and therefore to long-term remission. For one thing there is less strain on the patient's often tenuous adjustment to family living. Since family members are not responsible for supervising the patient's medical needs, they tend to be more accepting, and better feeling is promoted merely because the controlled delivery regimen demonstrates that improvement is possible. Controlled drug delivery also strengthens the patient's psychological defenses. He is not reminded of his psychiatric illness by multiple daily doses.

The same unique advantages of controlled drug delivery with Prolixin Decanoate that promote the discharge-

(Continued on following page)



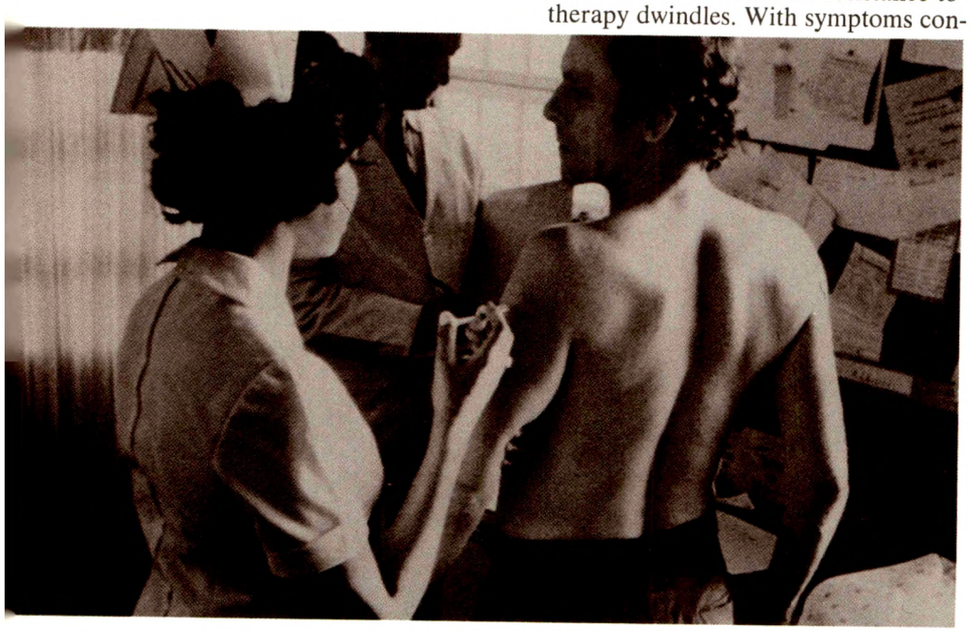
OD REASONS FOR CONTROLLED DRUG DELIVERY

(Continued from preceding page)
ability of the inpatient and help maintain him in the community are true for the patient who has never been hospitalized. It is just these advantages that will help the physician or psychiatrist keep him in the community without the need for custodial care.

Controlled drug delivery — a revolution in efficiency of administration

PROLIXIN® DECANOATE (Fluphenazine Decanoate Injection) SAVES TIME, REDUCES COST IN THE HOSPITAL, CLINIC, OFFICE

Controlled drug delivery saves time, reduces costs in the hospital. With Prolixin Decanoate there can be no palming, pouching, regurgitating. With Prolixin Decanoate resistance to therapy dwindles. With symptoms controlled, the patient is more manageable, more comfortable, more amenable to the total hospital treatment program. With Prolixin Decanoate only 1 dose visit every 1 to 3 weeks with an average of about 2 weeks is required.





Controlled drug delivery saves time, reduces costs in the clinic and office.

With Prolixin Decanoate less freque dosing. With Prolixin Decanoate (F phenazine Decanoate Injection) mc patients report for their injections on once in every 2-week period.

18 PATIENTS	18 PATIENTS
	
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Controlled drug delivery — a revolution in convenience of administration

PROLIXIN® DECANOATE (Fluphenazine Decanoate Injection) MAY BE DELIVERED IN EASY-TO-USE UNIMATIC® SYRINGES

Prolixin Decanoate may be give intramuscularly or subcutaneous Local tissue reactions occur only rare

A dry syringe and needle of at lea 21 gauge should be used. Use of a w needle or syringe may cause the so tion to become cloudy. Prolixin Dec noate is available in vials of 5 cc. ar in Unimatic single-dose preassemble syringes and in Unimatic cartrid needle units with a reusable-plast holder.

N.B. Extrapyramidal reactions c cur frequently. Most often they are r versible and can usually be controlle by administration of antiparkinsonia drugs. However, in some instanc they are persistent (see Adverse R actions section of Brief Summary Patients should be forewarned an reassured.

Reference: 1. Keskiner, A. et al.: Arch. G Psychiatry 18:477, Apr. 1968. 2. Goldbe H. L., DiMascio, A. and Chaudhary, B.: P chosomatics 11:173, May-June 1970. 3. M Clellan, T. A. and Cowan, G.: BRIE COMMUNICATIONS. Am. J. Psychiat 126:1771, June 1970. 4. Platt, R.: Br. J. Sc Psychiatry 2:187, 1968.

For Brief Summary, see opposite pag

Controlled Drug Delivery

in schizophrenia with new

PROLIXIN® DECANOATE

(FLUPHENAZINE DECANOATE INJECTION)

BRIEF SUMMARY
Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anti-cholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of anti-parkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage. A persistent and sometimes irreversible pseudo-parkinsonian syndrome may develop with chronic administration of phenothiazine compounds. Rhythmic, stereotyped dyskinetic involuntary movements, particularly of the face, mouth, tongue and jaw occur, and may be accompanied by choreiform movements of the limbs. The symptoms persist after drug withdrawal. Anti-parkinsonian agents are seldom of benefit. The risk appears to be greatest in elderly females with organic brain damage receiving large and prolonged doses. Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

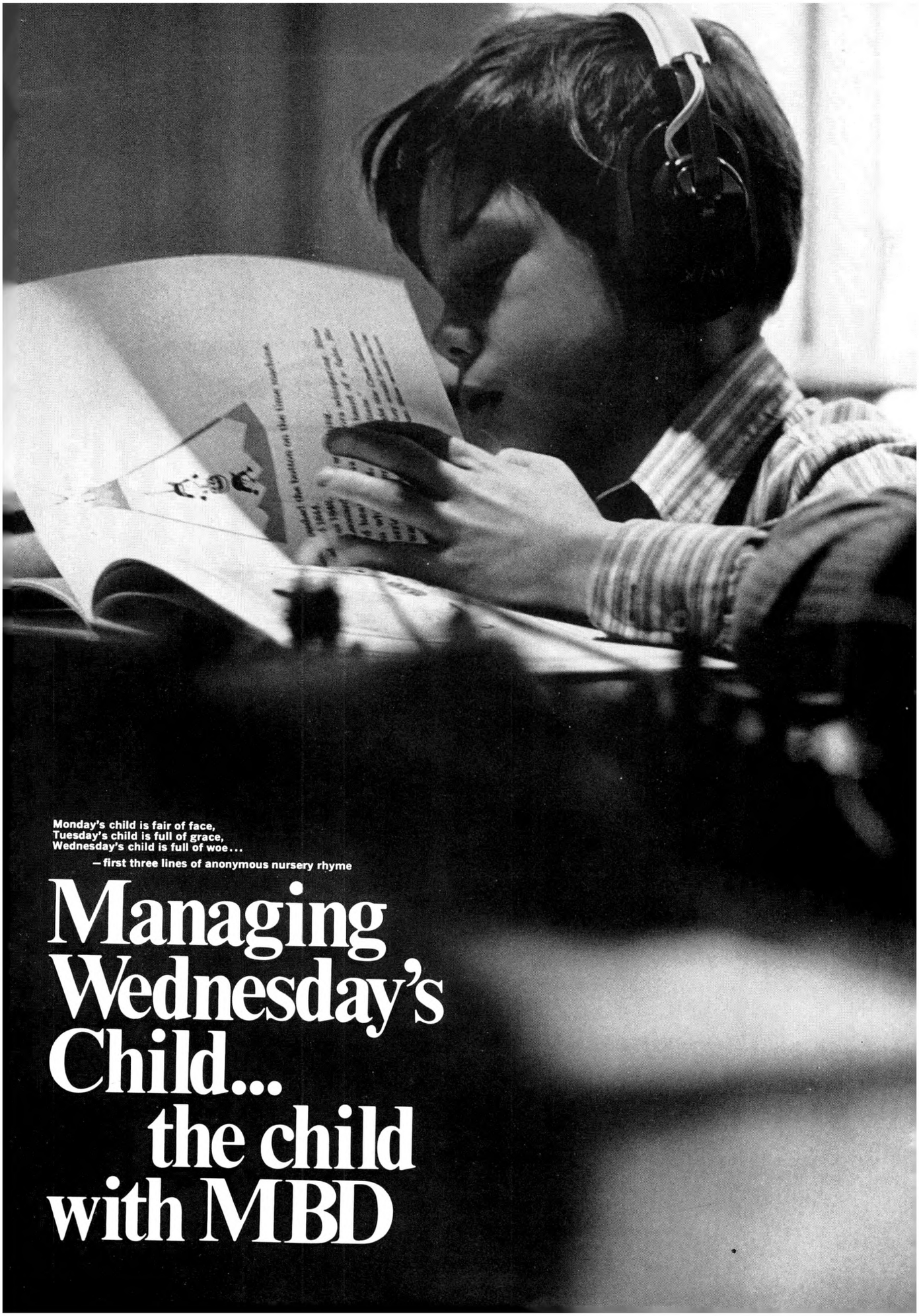
For full prescribing information, consult package insert.

Supply: 1 cc. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 cc. vials.



SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H783-004
Princeton, N.J. 08540



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD – Minimal Brain Dysfunction – can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference
1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION
Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)
Special Diagnostic Considerations
Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.
The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.
Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.
Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension.

Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.
Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION
Children with Minimal Brain Dysfunction (6 years and over)
Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.
If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.
Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.
Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

Ritalin®
(methylphenidate)
only when medication is indicated

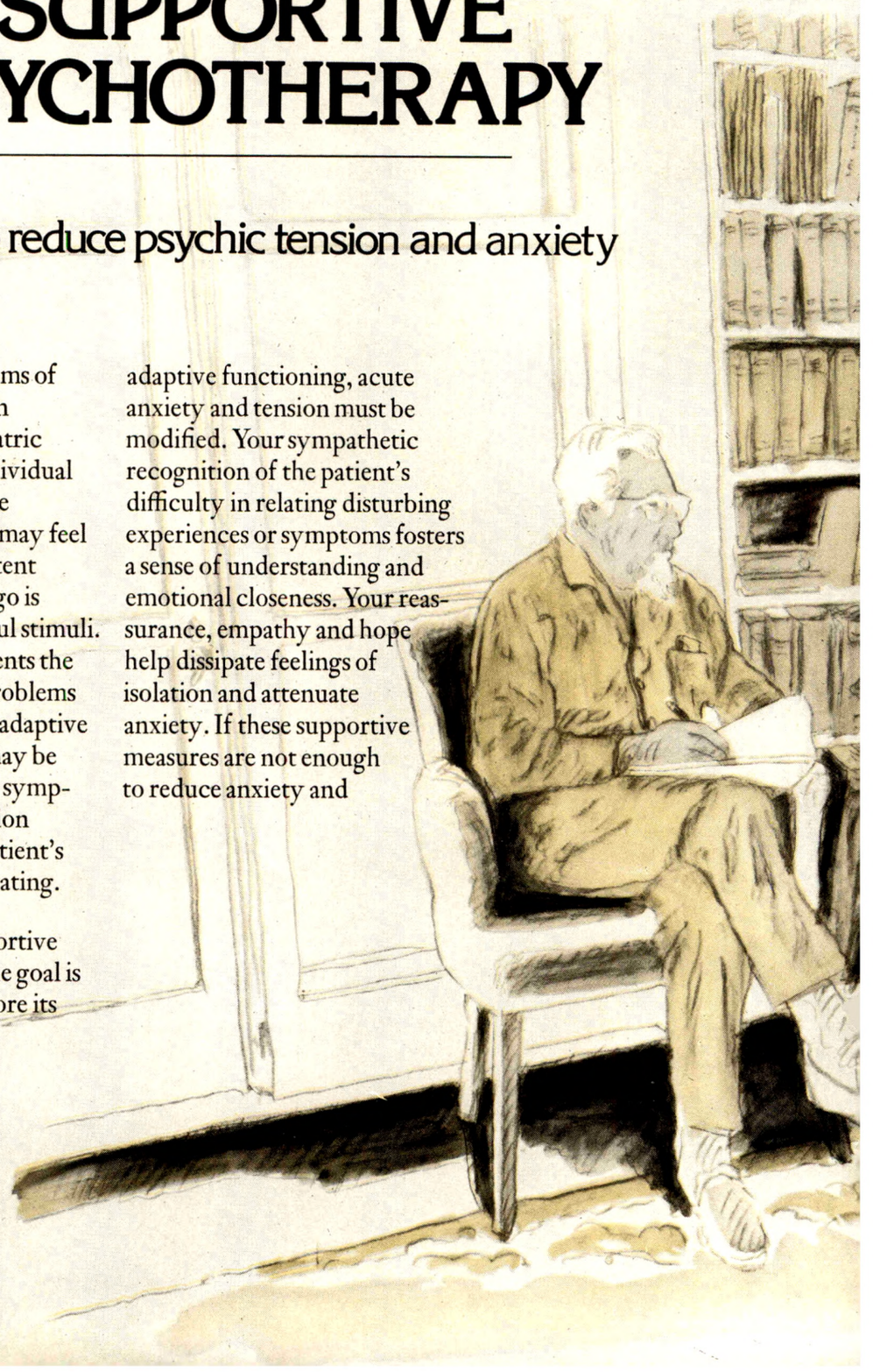
C I B A

VALIUM®
(diazepam)
IN THE CONTEXT OF SUPPORTIVE PSYCHOTHERAPY

To help reduce psychic tension and anxiety

Symptoms of anxiety and tension often appear when the psychiatric patient's self-esteem, individual integrity and security are threatened. The patient may feel out of control, incompetent and insecure when the ego is unable to manage stressful stimuli. If a state of tension prevents the patient from handling problems with calm and logic, the adaptive functioning of the ego may be further impaired. When symptoms of anxiety and tension become excessive, the patient's distress may be incapacitating.

In supportive psychotherapy where the goal is to brace the ego and restore its adaptive functioning, acute anxiety and tension must be modified. Your sympathetic recognition of the patient's difficulty in relating disturbing experiences or symptoms fosters a sense of understanding and emotional closeness. Your reassurance, empathy and hope help dissipate feelings of isolation and attenuate anxiety. If these supportive measures are not enough to reduce anxiety and



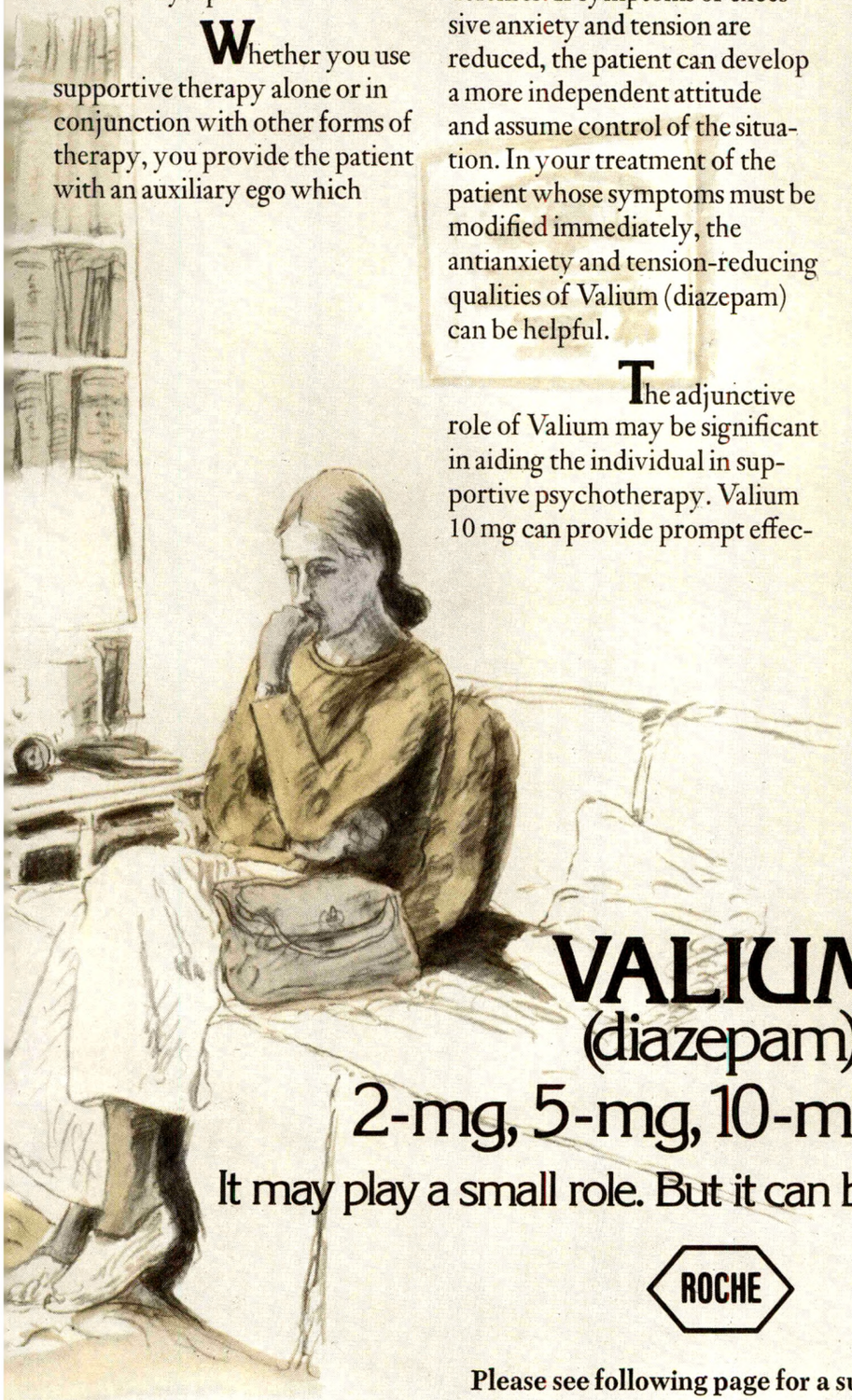
psychic tension to manageable levels, consider Valium (diazepam). Valium, used adjunctively with your supportive measures, can help stabilize your patient by minimizing these excessive symptoms.

Whether you use supportive therapy alone or in conjunction with other forms of therapy, you provide the patient with an auxiliary ego which shares the responsibility of *coping*. Your genuine reassurance and encouragement give the patient confidence and reduce undue stress from external pressures by fortifying ego defenses. If symptoms of excessive anxiety and tension are reduced, the patient can develop a more independent attitude and assume control of the situation. In your treatment of the patient whose symptoms must be modified immediately, the antianxiety and tension-reducing qualities of Valium (diazepam) can be helpful.

The adjunctive role of Valium may be significant in aiding the individual in supportive psychotherapy. Valium 10 mg can provide prompt effective action in minimizing or eliminating excessive psychic tension and anxiety. Once the symptoms are reduced to a manageable level, Valium (diazepam) may be continued as needed with 2 mg or 5 mg t.i.d. or q.i.d. or discontinued entirely.

Valium is generally well tolerated in the usual dosage range. The most frequently reported side effects have been drowsiness, fatigue and ataxia. Your patients should be cautioned against engaging in hazardous occupations or driving during Valium therapy.

When impaired ego function is accompanied by excessive anxiety and psychic tension, the patient needs your supportive help. If the symptoms are incapacitating and must immediately be reduced, consider Valium as an adjunctive psychotherapeutic aid.



VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets
It may play a small role. But it can be an important one.

ROCHE

Please see following page for a summary of product information.

VALIUM®
(diazepam)
2-mg, 5-mg, 10-mg tablets



In the context of supportive psychotherapy, helps reduce psychic tension and anxiety.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

from USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows... maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS

MOVING?

PLEASE NOTIFY US 6 WEEKS IN ADVANCE

Change of address or name for THE AMERICAN JOURNAL OF PSYCHIATRY and/or PSYCHIATRIC NEWS. Please use only one address for APA mailings. Thank you.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS OR NAME:
(The number of characters indicated include spaces.)

APA IDENTIFICATION NO. (6 characters)

NAME: (24 characters)

(last) (first) (middle initial)

STREET ADDRESS: line #1 (24 characters)

STREET ADDRESS: line #2 (24 characters)

CITY: (16 characters)

STATE: (2 characters)

ZIP: (7 characters)

MAIL TO:

Division of Manpower Research
and Development
AMERICAN PSYCHIATRIC ASSOCIATION
1700 Eighteenth St., N.W.
Washington, D. C. 20009

INDEX TO ADVERTISERS

July 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

AYERST
Antabuse A12–A13

CHARLES C THOMAS • PUBLISHER A23

CIBA PHARMACEUTICAL COMPANY
Ritalin A6–A7
Ritalin MBD A58–A59

CYBORG CORPORATION A27

DEVEREUX FOUNDATION C4

DOW PHARMACEUTICALS
Quide A8–A10

GENERAL INDUSTRIES
Neurological Stimulator A26

KNOLL PHARMACEUTICAL
Akineton A33

LAKESIDE LABORATORIES
Norpramin A66–C3

LEDERLE
Artane A18–A19
Stresstabs A11

McNEIL LABORATORIES, INC.
Haldol A49–A50

MERCK SHARP & DOHME
Elavil A42–A44
Triavil A14–A17
Vivactil A30–A31

PFIZER, INC.
ROERIG DIVISION
Navane A37–A39

REUBEN REITER, ScD. INC.
Electrostimulators A51

ROCHE LABORATORIES
Librium A24–A25
Valium A60–A62

SANDOZ
Mellaril A32
Serentil A34–A36

SANITARIUMS AND PRIVATE HOSPITALS ... A26, A27

SCHERING CORPORATION
Etrafon A45–A47

SMITH KLINE AND FRENCH LABORATORIES
Stelazine A40–A41
Thorazine C2

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A53–A57

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A63
Pertofrane A28–A29

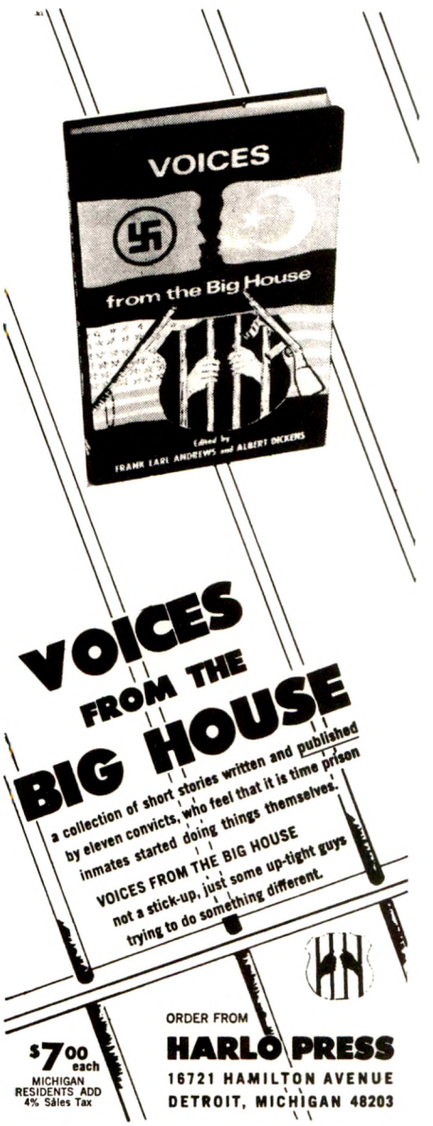
WYETH LABORATORIES
Serax A20–A22

YOU'RE
WHISTLING
IN THE
DARK...

IF YOU
THINK THAT
HEART DISEASE
AND STROKE
HIT ONLY THE
OTHER FELLOW'S
FAMILY.

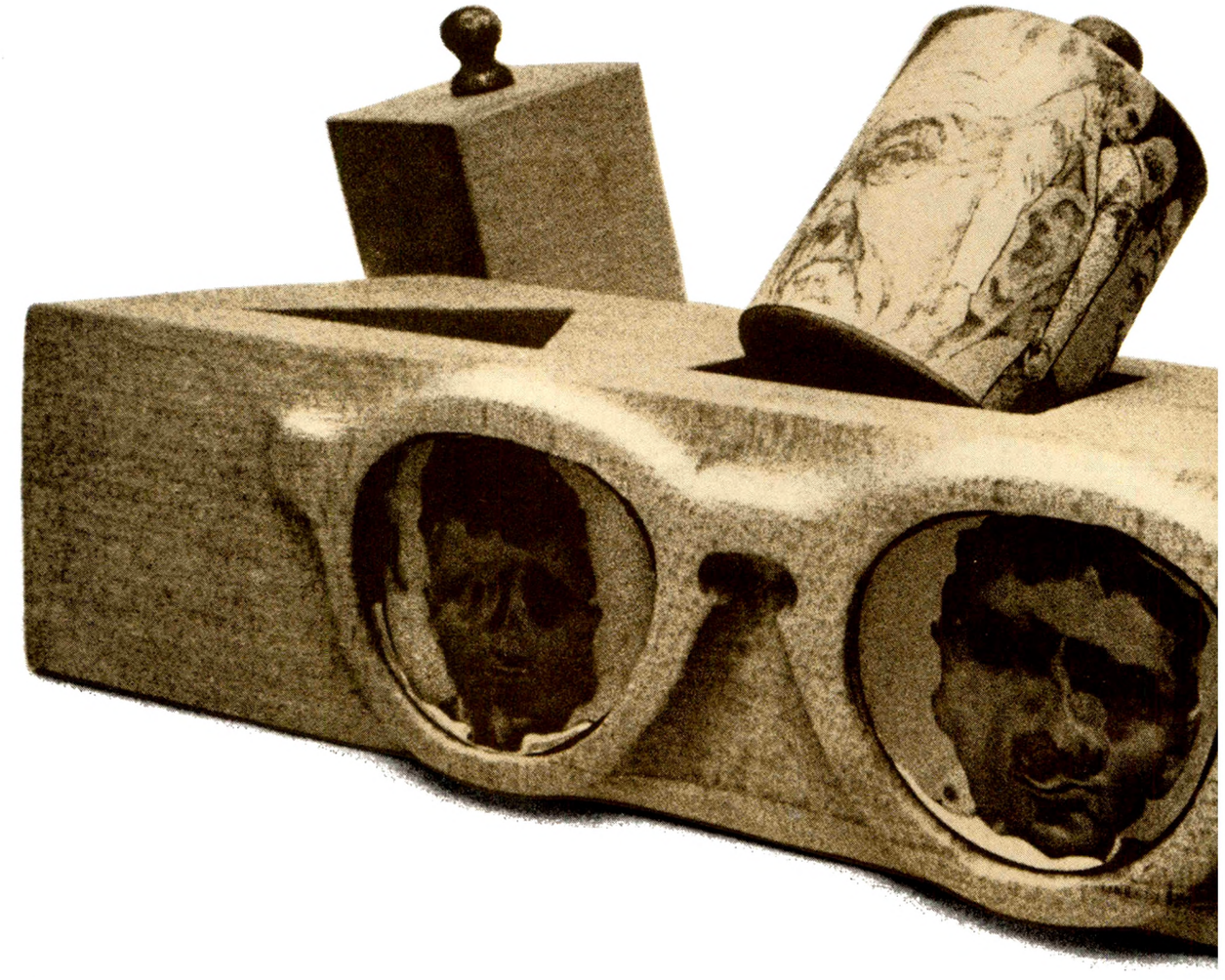
GIVE...
so more will live
HEART
FUND

Contributed by the Publisher



Book dealers and wholesalers. 40% discount on orders of 5 or more copies. 50% discount on orders of 25 or more copies.

H lp imprv yoUI d pr d
patients' ability to cope.



In Brief:

Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.

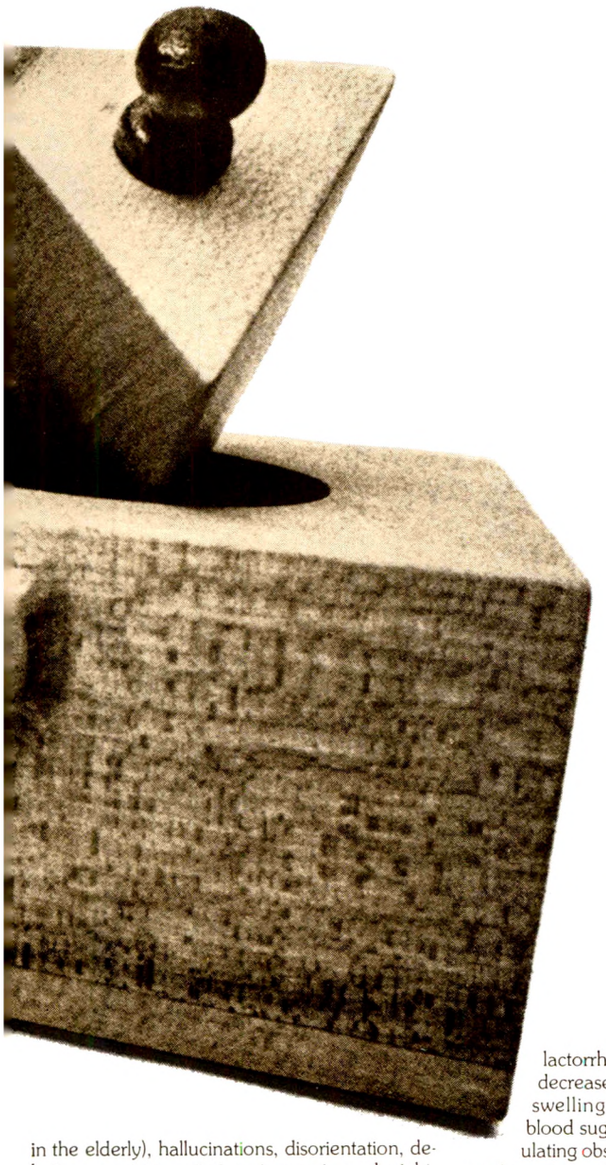
Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosis in schizophrenic patients. Close supervision and careful adjustment of dosage are required when this drug is given along with anticholinergic or sympathomimetic drugs. While taking this drug, response to alcoholic beverages may be exaggerated. There is limited clinical experience in the concurrent administration of ECT and antidepressant drugs; thus, one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

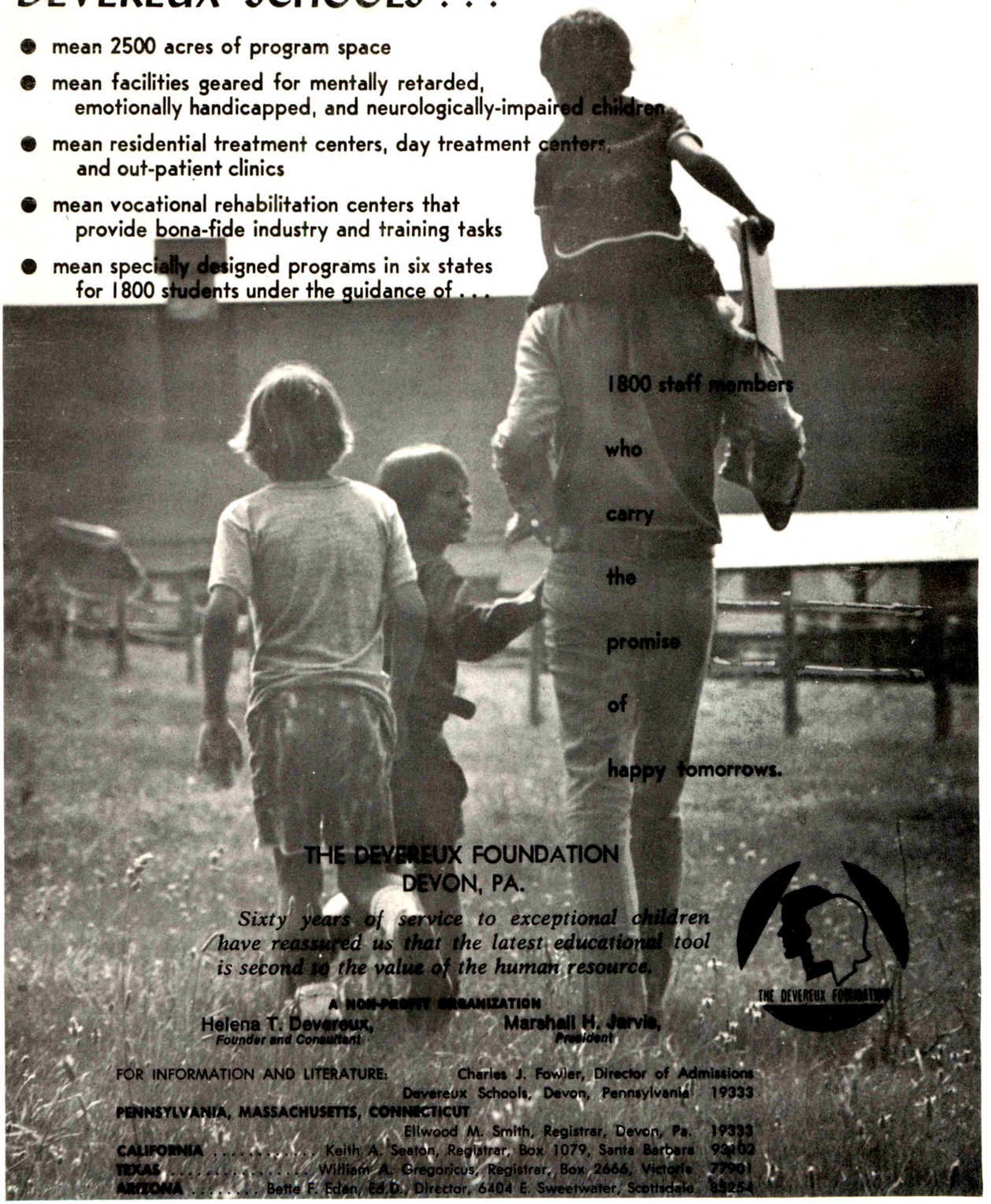
How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.*, sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.*, sugar coated tablets, light green, in bottles of 50, 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

DEVEREUX SCHOOLS . . .

- mean 2500 acres of program space
- mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impaired children
- mean residential treatment centers, day treatment centers, and out-patient clinics
- mean vocational rehabilitation centers that provide bona-fide industry and training tasks
- mean specially designed programs in six states for 1800 students under the guidance of . . .



1800 staff members who carry the promise of happy tomorrows.

THE DEVEREUX FOUNDATION
DEVON, PA.

Sixty years of service to exceptional children have reassured us that the latest educational tool is second to the value of the human resource.

A NON-PROFIT ORGANIZATION

Helena T. Devereux, *Founder and Consultant*

Marshall H. Jarvis, *President*

THE DEVEREUX FOUNDATION

FOR INFORMATION AND LITERATURE: Charles J. Fowler, Director of Admissions
Devereux Schools, Devon, Pennsylvania 19333

PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT
Ellwood M. Smith, Registrar, Devon, Pa. 19333

CALIFORNIA . . . . . Keith A. Seaton, Registrar, Box 1079, Santa Barbara 93102

TEXAS . . . . . William A. Gregoricus, Registrar, Box 2666, Victoria 77901

ARIZONA . . . . . Bette F. Eden, Ed.D., Director, 6404 E. Sweetwater, Scottsdale 85254

Vol. 130, No. 8 August 1973

THE AMERICAN JOURNAL OF PSYCHIATRY

Overview Article

Ransom J. Arthur on Social Psychiatry

This Month's Special Section

Aspects of Hospitalization

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

LIBRARY

Thorazine® offers you a choice.

brand of chlorpromazine

18 Dosage Forms and Strengths

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.

Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.

Injection, 25 mg./ml.

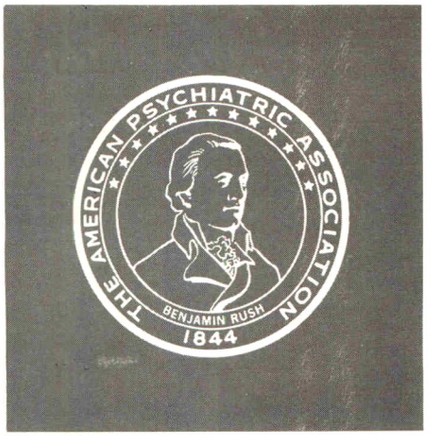
Syrup, 10 mg./5 ml.

Suppositories, 25 mg. and 100 mg.

Concentrate, 30 mg./ml. and 100 mg./ml.



SK&F Smith Kline & French Laboratories, Philadelphia



THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

The American Journal of Psychiatry, formerly *The American Journal of Insanity*, is published monthly by the American Psychiatric Association. Editorial office: 1700 Eighteenth Street, N.W., Washington, D.C. 20009; telephone (202) 232-7878.

Subscriptions: U.S. $15.00 per year, Canada and South America $15.75, other foreign $18.00; single issues: $1.75 plus postage.

APA members should direct changes of address and communications about nonreceipt of the *Journal* to the Manpower Division, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

Communications from nonmember subscribers and all business communications should be directed to Mr. Robert J. Lowe, Publications Services Division, at the same address.

Advertising representatives: Steven K. Herlitz, Inc., 850 Third Avenue, New York, N.Y. 10022.

Type set by Bru-El Graphic, Inc., 5265 Port Royal Road, Springfield, Va. 22151.

Printed by Dartmouth Printing Co., 69 Lyme Road, Hanover, N.H. 03755.

Second class postage paid at Washington, D.C., and additional mailing offices.

Indexed in *Abstracts for Social Workers, Biological Abstracts, Chemical Abstracts, Cumulative Index to Nursing Literature, Excerpta Medica, Hospital Literature Index, Index Medicus, International Nursing Index, Nutrition Abstracts*, and *Psychological Abstracts*.

Copyright© 1973, the American Psychiatric Association.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers

Assistant Managing Editor
Amy E. Shaughnessy

Senior Assistant Editor
Linda A. Loy

Assistant Editors
Heidi A. Halter
Laura M. Little
James Johnson

Editorial Assistant
Katherine P. Olinick

Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.

THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 8 August 1973

841 Social Psychiatry: An Overview
Ransom J. Arthur

850 Reentry: II. "Making It" Back in the States
Jonathan F. Borus

855 Acupunctural Analgesia: Its Explanation by Conditioning Theory, Autogenic Training, and Hypnosis
William S. Kroger

861 Crisis, Conversion, and Cult Formation: An Examination of a Common Psychosocial Sequence
Herbert M. Adler and Van Buren O. Hammett

865 Telepsychiatry: Psychiatric Consultation by Interactive Television
Thomas F. Dwyer

870 Factors Affecting Referral to Determine Competency to Stand Trial
Gerald Cooke, Norman Johnston, and Eric Pogany

876 Resentment and Suspicion Among American Men
Monica D. Blumenthal

881 Illnesses of the Spirit Among the Serer of Senegal
Morton Beiser, Winthrop A. Burr, Jean-Louis Ravel, and Henri Collomb

SPECIAL SECTION: *Aspects of Hospitalization*

887 The Practice of Hospital Psychiatry: A Formulation
Gary J. Tucker and Jerrold S. Maxmen

892 Judgments of Alternatives to Hospitalization
Steven H. Lipsius

896 Brief Hospitalization on a Crisis Service: A Study of Patient and Treatment Variables
W. Ray Walker, Lowell B. Parsons, and W. Douglas Skelton

900 Utilization Review of Psychiatric Inpatient Care
Alex Richman and Henry Pinsker

904 Relationships Between Length of Stay in and out of the New York State Mental Hospitals
Abbott S. Weinstein, Diane DiPasquale, and Frederick Winsor

EDITORIALS

910 If They Were Here Now
J. Martin Myers

911 Care of the Chronically Mentally Ill—A National Disgrace
Robert Reich

BRIEF COMMUNICATIONS

913 A Criterion Approach to Patient Care Evaluation
Gary L. Tischler and Donald C. Riedel

916 Group Process Research: A Factor Analytical Study
David M. Hawkins, C. Bryan Norton, Carl Eisdorfer, and Daniel Gianturco

920 Group Psychotherapy Supervision and Its Effect on Resident Training
William K. Grossman and Edward Karmiol

922 Methylphenidate in Tardive Dyskinesia
William E. Fann, John M. Davis, and Ian C. Wilson

925 Management of Tardive Dyskinesia with Thiopropazate
John P. Curran

927 Urinary Cyclic AMP in Periodic Catatonia
Thomas L. Perry, Susan Hemmings, George I. Drummond, Shirley Hansen, and Liev R. Gjessing

930 Collaborative Provision of Aftercare Services
Robert M. Prince, Jr., Raymond E. Ackerman, and Barbara S. Barksdale

933 Teenage Helper: A Role in Community Mental Health
G.A. Rogeness and R.A. Bednar

---

937 LETTERS TO THE EDITOR

943 BOOK REVIEWS

OFFICIAL ACTIONS

950 Position Statement on Aging

952 Committee on Certification in Administrative Psychiatry

A56 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of each article: 60–100 words for regular articles, 40–60 words for Brief Communications. The author may prepare the precis himself or ask that the *Journal* staff prepare it, in which case the author may make any necessary changes on the galley proofs.

References. References should be typed double-spaced on a separate sheet of paper, to be attached at the end of the manuscript. They should be arranged according to their order of appearance in the text, where they should be indicated by numbers in parentheses. Reference citations should be restricted to closely pertinent papers; a complete review of the literature is rarely desirable, except in the case of review articles for which a special arrangement has been made with the Editor.

References should be typed in accordance with the style shown below for books and journal articles; chapters in books will be treated as journal articles with regard to capitalization. Up to three authors should be listed; one or more authors past the third will be designated "et al." Abbreviations of journal names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and figures should be sufficiently clear that the meaning of the data is understandable without reference to the text. See recent issues of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attached at the end of the manuscript. The data should be arranged so that columns of like material read down, not across.

A complete set of figures, preferably in the form of glossy prints, should accompany each of the two copies of the manuscript. Most figures will be reduced to about $3^1/_4$ inches in width, the column width of the *Journal*; all elements of a figure should be prepared to withstand this reduction. Graphs should be finished drawings not requiring further artwork. Authors are urged to engage the services of a professional in the preparation of figures. Authors may be required to meet the costs of any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for corrections after the paper has been scheduled for publication; prompt return (preferably within 48 hours of receipt) is necessary to ensure publication in the assigned month. If an author expects to be away from his office for a long period of time after he has received the acceptance letter, he should inform the *Journal* office or arrange with a colleague to read the proofs. Authors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the galley proofs submitted to authors for correction. Reprints are usually mailed to authors about a month after publication of the article. Requests from others to order reprints should be directed to the Editor; inclusion of a letter of permission from the senior author and a brief statement of the intended use of the reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG
HERBERT KLEMMER
ALAN A. STONE
PERRY C. TALKINGTON

For two years: EWALD W. BUSSE
HENRIETTE R. KLEIN
MELVIN SABSHIN
JOHN R. SAUNDERS

For one year: ROBERT S. GARBER
JOHN E. NARDINI
IRVING PHILIPS
CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN

Constitution and By-Laws
WINFRED OVERHOLSER, JR.

Ethics

Membership
ALEXANDER LEVINE

Nominating
HOWARD P. ROME

Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN

Academic Education
HAROLD MCPHEETERS

Drug Abuse and Drug Education
PETER BOURNE

School Consultation
SHELDON D. GLASS

Conference on Family Life Education
ARNOLD M. KALLEN

Certification in Administrative Psychiatry
ARCHIE R. FOLEY

History

Medical Education
HAROLD I. KAPLAN

Psychiatry and Medical Practice
ROBERT A. SENESCU

Continuing Education
JAMES NAIMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG

Transcultural Psychiatry
RAMON PARRES

Joint Meeting in Australia 1975
ALFRED AUERBACK

Psychiatry and Foreign Affairs
WILLIAM D. DAVIDSON

Inter-American Council of Psychiatric Associations
HOWARD P. ROME

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER

Women in Psychiatry
NANCY A. ROESKE *and* ELISSA P. BENEDECK

Psychiatric Involvement in Family Planning
EUGENE B. BRODY

Psychosurgery
JOHN DONNELLY

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE

Drug Abuse
DANIEL X. FREEDMAN

Nomenclature and Statistics
HENRY BRILL

Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION

Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER

Lithium Therapy
IRVIN M. COHEN

Meditation
JAMES MORGAN

Effects of Television on Mental Health
JAMES H. RYAN

Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS

Psychiatry and the Law
STANLEY L. PORTNOW

Liaison with American Hospital Association
GERALD R. CLARK

Liaison with American College of Physicians
CHARLES P. NEUMANN

Psychiatric Nursing
WILLIAM E. STONE

Interprofessional Relations
WILLIAM W. ZELLER

Right to Treatment
BERNARD DIAMOND

Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN

Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON

Financing of Mental Health Care
JOHN M. COTTON

Federal Government Health Services
STEWART BAKER

Childhood and Adolescence
VIOLA BERNARD

Private Psychiatric Hospitals
JOHN H. HOUCK

Suicide Prevention
MATHEW ROSS

Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD

APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON

Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE

Professional Standards Review Organizations
FRANK SULLIVAN

COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT

Program
H. KEITH H. BRODIE

Film Review
EDWARD A. MASON

Closed-Circuit TV Presentations
MILTON BERGER

Arrangements
BENJAMIN JEFFRIES

Conventions
ALEXANDER SIMON

Scientific Exhibits
ROBERT FROELICH

Awards for Scientific Exhibits
SARA DUBO

Public Information
JAMES P. CATTELL

Member Insurance and Retirement Plans
CHESTER TRENT

Trustees of APA Retirement Plan
SANFORD L. BILLET

House
DANIEL JAFFE

Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON

Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.

Isaac Ray Award
JOHN K. TORRENS

Manfred S. Guttmacher Award
JONAS R. RAPPEPORT

Hofheimer Prize
DONALD F. KLEIN

McGavin Award
NORBERT B. ENZER

Vestermark Prize
BERTRAM S. BROWN

Grants and Awards
JACK WEINBERG

Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL

Black Psychiatrists
JAMES P. COMER

Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT

Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ

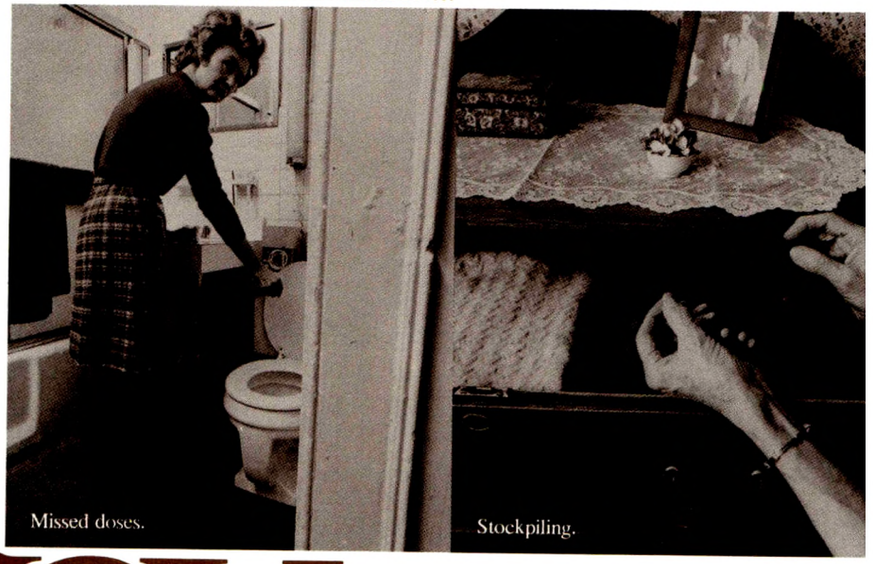
Indian Affairs
MORTON BEISER

Comprehensive Health Planning
ROBERT L. WILLIAMS

Third-Party Intervention in Community Crises
FRANK OCHBERG

Legislative Network
HAYDEN H. DONAHUE

FOUR REASONS FOR READMISSION...



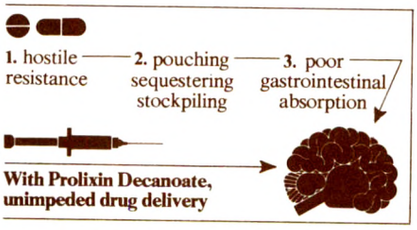
For schizophrenic patients...

A way out

that helps them stay out

Controlled Drug Delivery with
PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)
Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer, with an average duration of effect of about 2 weeks

Controlled drug delivery helps prevent disruption of therapy—one of the commonest causes of psychotic relapse. For the inpatient it means unimpeded drug delivery with improved chances of discharge.



For the outpatient it means improved chances for prolonged remission: "...the duration of remission and the incidence of relapse are directly related to keeping the patient medicated after his return to the community."[1]

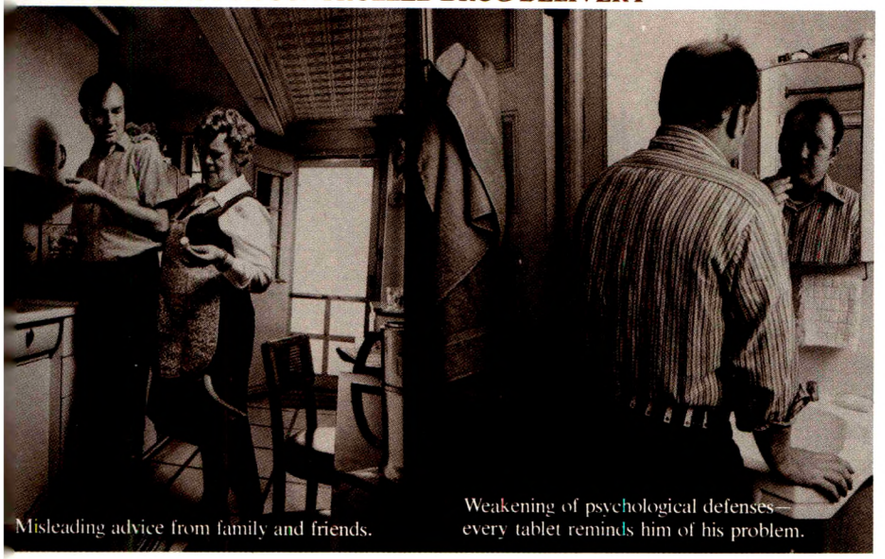
Controlled drug delivery helps the inpatient out

- Keeps the patient medicated...helps make him more manageable, more comfortable, and more amenable to total treatment. With oral medication, on the other hand, approximately one out of every five patients does not take his medication, even when administered by the nursing staff.[2]
- Eliminates the problem of missed, lost, or hidden doses. Prevents stockpiling.
- Assures regular medication intake.
- Lightens responsibilities of the hospital staff...simplifies patient management by obviating the need for multiple doses.
- Increases the likelihood of discharge: In one study[3] of 24 long-term hospital patients treated with Prolixin Decanoate (Fluphenazine Decanoate Injection) every 7 days to 3 weeks:

DISCHARGED	CONSIDERED DISCHARGEABLE	NO IMPROVEMENT
13	4	7

Dischargeability "may also have been enhanced because the staff, the patient, and the family were assured of an adequate and regular medication intake."[3]

GOOD REASONS FOR CONTROLLED DRUG DELIVERY



Misleading advice from family and friends.

Weakening of psychological defenses—every tablet reminds him of his problem.

Controlled drug delivery helps keep the outpatient out

- Helps assure continuity of medication ...makes prolonged remission more likely. With oral medication, on the other hand, "approximately 50% of all discharged psychotic patients fail to take even the first dose of their outpatient medication."[2]
- Enhances chances for rehabilitation... promotes acceptance socially, in the family, and on the job because of sustained control of symptomatology.
- Eases family adjustment by eliminating concern about "taking his medicine."
- Avoids the potential dangers of stockpiling, particularly for the suicidal.
- Once administered, therapy cannot be altered by the patient, by his family, or by anyone else.
- The unique advantages of controlled drug delivery apply equally to the patient who has never been hospitalized.

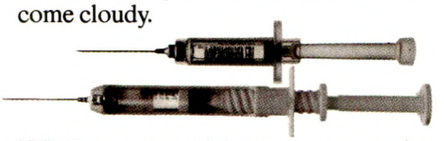
They are advantages that can help make custodial care unnecessary as long as treatment continues.

Controlled drug delivery saves time, reduces cost in the hospital, clinic, office
Saves time in the hospital:

18 PATIENTS	18 PATIENTS
	
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Saves time in the clinic and in the office: Most patients report for their injections only once in every two-week period.

Prolixin Decanoate (Fluphenazine Decanoate Injection) also offers the convenience of easy-to-use Unimatic® Syringes: Unimatic single-dose preassembled syringes and Unimatic cartridge-needle units with a reusable plastic holder. Vials of 5 cc. Prolixin Decanoate are available for use with dry syringes and needles (at least 21 gauge). Use of a wet needle may cause the solution to become cloudy.



N.B. Extrapyramidal reactions occur frequently. Most often they are reversible and can usually be controlled by administration of antiparkinsonian drugs. However, in some instances, they are persistent—particularly in the case of tardive dyskinesia (see Adverse Reactions section of Brief Summary). Patients should be forewarned and reassured.

References: 1. Kinross-Wright, V. J.: Cited in Med. Tribune, Sept. 13, 1965, pp. 1, 27. 2. Goldberg, H. L., DiMascio, A. and Chaudhary, B.: Psychosomatics 11:173, May-June 1970. 3. Keskiner, A. et al.: Arch. Gen. Psychiatry 18:477, Apr. 1968. 4. Platt, R.: Br. J. Social Psychiatry 2:187, 1968.

Controlled Drug Delivery *with* PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)

For product Brief Summary, see following page.

SQUIBB HOSPITAL DIVISION

Controlled Drug Delivery

in schizophrenia with

PROLIXIN® DECANOATE

(FLUPHENAZINE DECANOATE INJECTION)

BRIEF SUMMARY

Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy. Safety and efficacy in children have not been established because of inadequate experience in use in children.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anticholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of antiparkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 cc. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 cc. vials.



SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H423-023

Princeton, N. J. 08540



Withdrawn and uncommunicative?...Or responsive?

While psychotic symptoms remain acute, the barrier between you and the withdrawn, uncommunicative patient may be insurmountable. Prompt intervention with HALDOL (haloperidol) often makes it possible for you to reach... relate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

responsiveness often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

© McNeil Laboratories, Inc., 1973

Haldol®
(HALOPERIDOL)

a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: For the treatment of such symptoms as moderate to severe agitation, anxiety and tension, assaultiveness, delusions, hallucinations, hostility, and hyperactivity when they are manifestations of psychosis including schizophrenia, the manic type of manic depressive illness, or psychotic reactions associated with organic brain syndromes or mental retardation. For the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy***—Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children—Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General—Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold, although it will *not* increase the effects of anticonvulsant medication. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 11/72

McNEIL McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

now available

the latest 3 volumes in the proceedings of The American Psychopathological Association

Psychopathology and Psychopharmacology

Edited by JONATHAN O. COLE, ALFRED M. FREEDMAN, and ARNOLD FRIEDHOFF

Leading researchers here give accounts of current investigations into the use of drugs in treating mental illness. They also consider ways in which drugs have been used recently to simulate schizophrenia. Their analysis of drug models and schizophrenia covers not only drugs usually considered schizophrenic-like in their effect — LSD and the amphetamines — but also atropine-like agents, phencyclidine, and marihuana.

$15.00

Contemporary Sexual Behavior

Critical Issues in the 1970s

Edited by JOSEPH ZUBIN and JOHN MONEY

Two dozen experts on the psychology, physiology, and biochemistry of sexual behavior consider the new feminism and women's sexuality, the use of drugs in treating sex offenders, public attitudes toward sex education and pornography, and recent animal research on sexual behavior.

$15.00

Disorders of Mood

Edited by JOSEPH ZUBIN and FRITZ A. FREYHAN

". . . the present volume's dual stress on psychopharmacology and classification seems timely and well founded. . . . An excellent collection of papers which well mirror much of the current excitement in affective research and theory." — *Contemporary Psychology*

$12.50

JOHNS HOPKINS

The Johns Hopkins University Press
Baltimore, Maryland 21218



THE AMERICAN JOURNAL OF PSYCHIATRY

NOW, your journals can become an attractive permanent part of your professional library. These famous Jesse Jones volume files, especially designed to keep your copies orderly, readily accessible for future reference—guard against soiling, tearing, wear or misplacement of copies. These durable files will support 150 lbs. Looks and feels like leather and is washable. The 23-carat gold lettering makes it a fit companion for the most costly binding.

Reasonably priced, too. Only $4.25, 3 for $12.00, 6 for $22.00 POSTPAID U. S. A. ORDERS ONLY. Satisfaction unconditionally guaranteed or your money back.

JESSE JONES BOX CORP. (Since 1843)
Department JP9—Philadelphia 41, Pa. 19141

CAN MENTAL ILLNESS BE INHERITED?

That's the question that spurred this remarkable study—initiated in the early 1900's and carried on by two generations of researchers. They investigated up to five generations of the original patients' families—kinships as large as 1907 members. The resulting insights into the transmission and frequency of mental illness are available in a penetrating new book,

The Psychoses: Family Studies

by **Sheldon C. Reed,** *Ph.D.,* **Carl Hartley,** *Ph.D.,* **V. Elving Anderson,** *Ph.D.,* **Vivian P. Phillips,** *B.S., and* **Nelson A. Johnson,** *M.S.W., of the Dight Institute for Human Genetics, Univ. of Minnesota, and the Warren State Hospital, Warren, Pa. About 560 pp., 220 figs. About $20.00. Just Published.*

☐ Send and bill me for 7507 Reed: The Psychoses

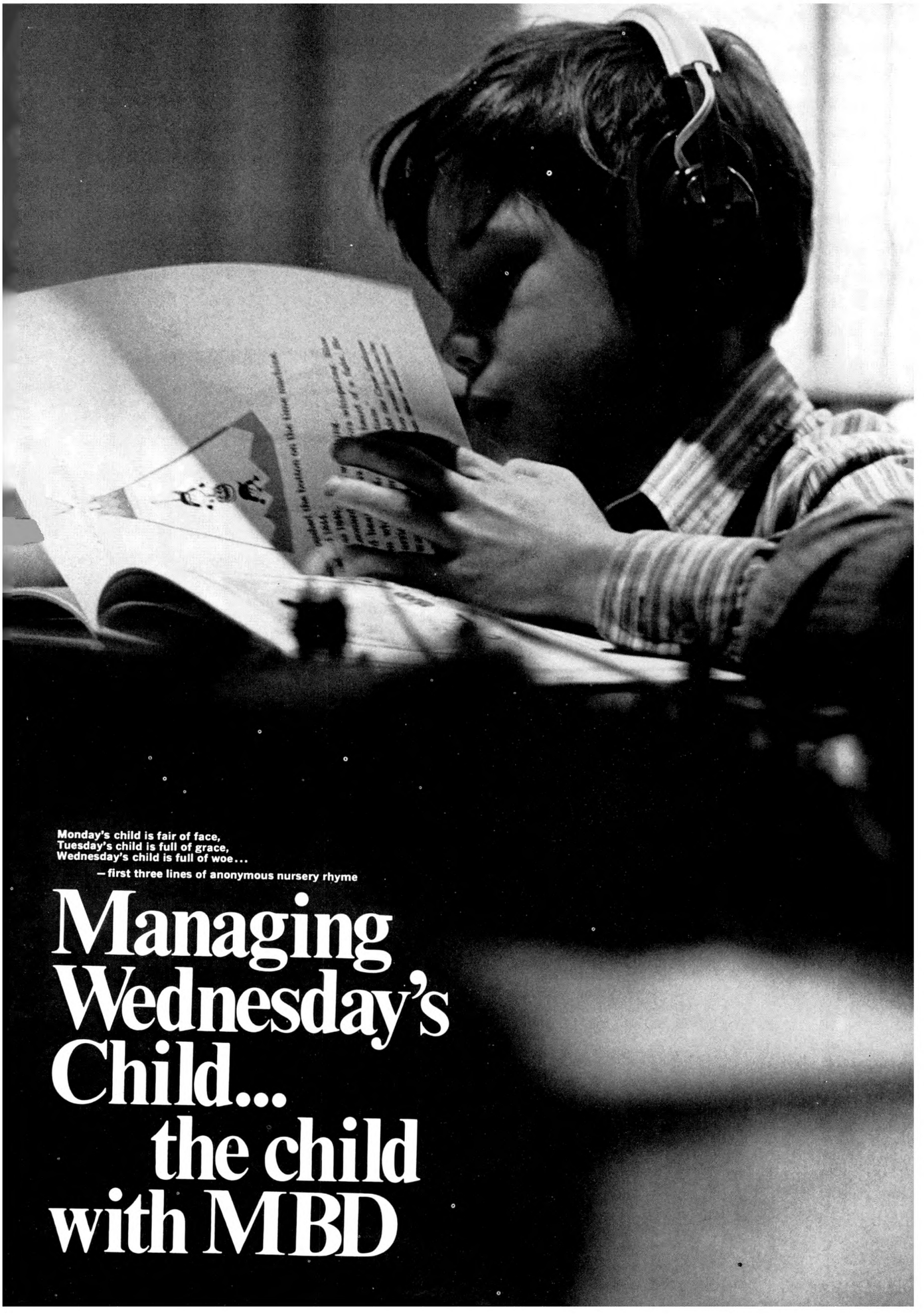
NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

AJP873

W.B. SAUNDERS COMPANY
West Washington Square, Philadelphia, Pa. 19105



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD – Minimal Brain Dysfunction – can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference

1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established. Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

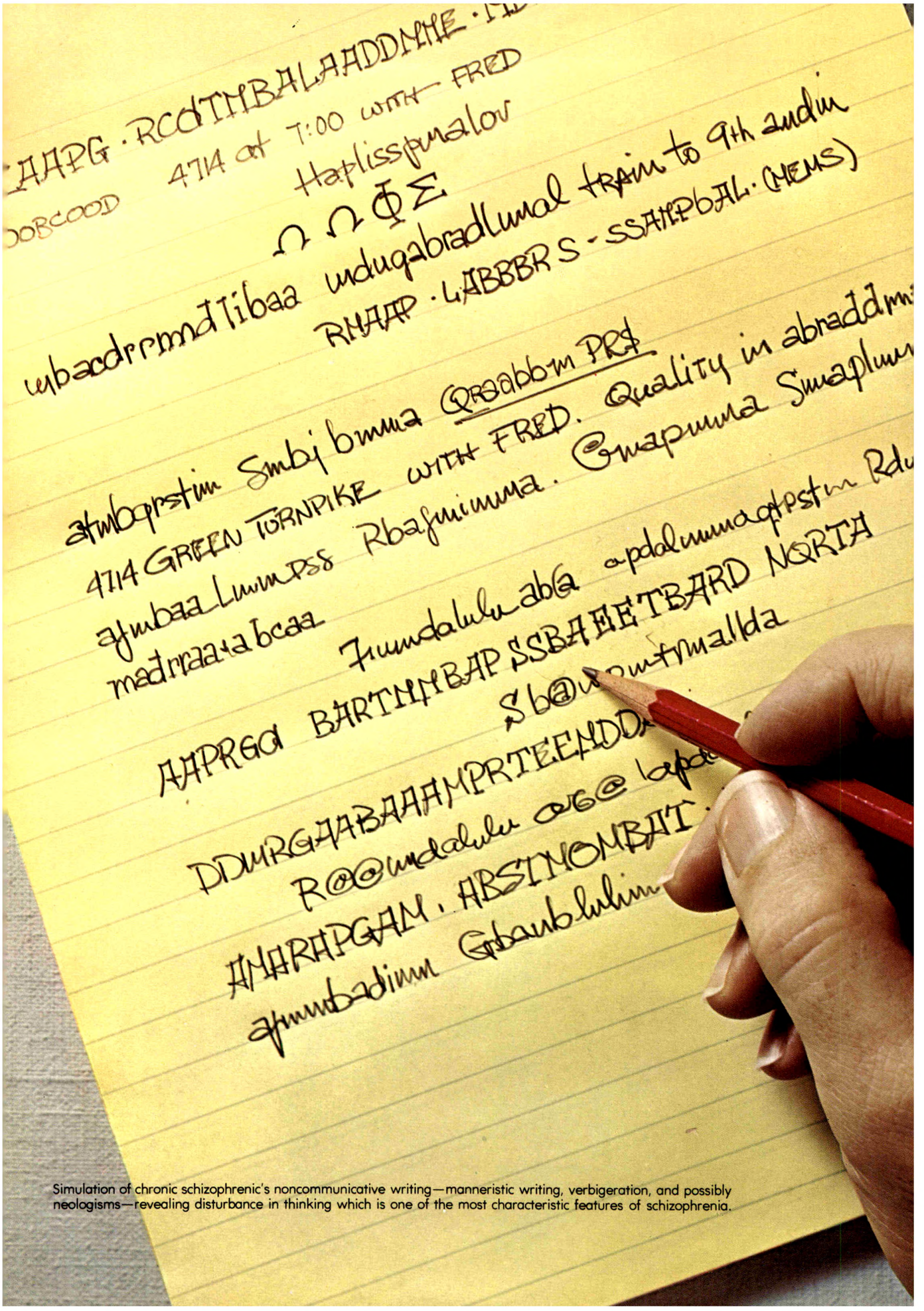
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

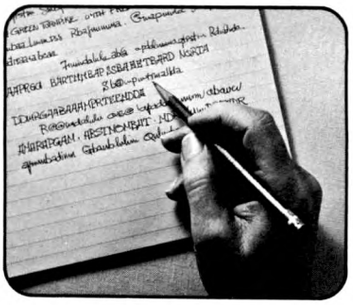
Ritalin®
(methylphenidate)
only when medication is indicated

C I B A



Simulation of chronic schizophrenic's noncommunicative writing—manneristic writing, verbigeration, and possibly neologisms—revealing disturbance in thinking which is one of the most characteristic features of schizophrenia.


Unusual thought content...
a target symptom in schizophrenia that responds particularly well to treatment with SERENTIL®
(mesoridazine)
Tablets, 50 mg. (as the besylate)
The disturbances in thinking and conceptualization that are most characteristic of schizophrenia are particularly responsive to treatment with Serentil. Symptoms of unusual thought content, conceptual disorganization, and hallucinatory behavior—whatever their degree of severity—are potentially reversible.
Serentil is effective in both acute and chronic forms of schizophrenia. Serentil Tablets and Concentrate provide dosage flexibility for initiating and maintaining therapy for both hospitalized and discharged patients.
The injectable form of Serentil is especially valuable for efficient management of symptoms in many newly admitted patients and for rapid control of acute episodes in office practice.
For brief summary, please see following page.
SANDOZ
73-731

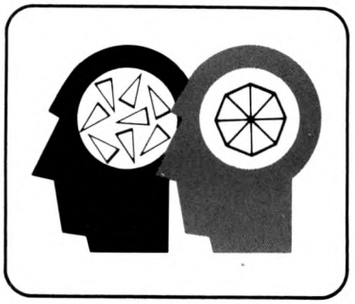


Unusual thought content...

a target symptom in schizophrenia that responds particularly well to treatment with

SERENTIL®
(mesoridazine)

Tablets, 50 mg. (as the besylate)



Contraindications: Severe central nervous system depression, comatose states, hypersensitivity.

Warnings: Increase dosage gradually to patients participating in activities requiring complete mental alertness (e.g., driving). The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus. Use in children under 12 is not recommended. Phenothiazines are capable of potentiating central nervous system depressants as well as atropine and phosphorus insecticides.

Precautions: Ocular changes (seen with other phenothiazines) have not been seen with Serentil (mesoridazine). Because of possible hypotensive reactions, caution in parenteral use is required. Reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection. Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. Blood dyscrasia (seen with other phenothiazines) has occurred in a single case of transient granulocytopenia.

Adverse Reactions: Serentil (mesoridazine) has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds. *Central Nervous System:* Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos). *Autonomic Nervous System:* Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision. *Endocrine System:* Inhibition of ejaculation and lactation have been noted rarely. *Skin:* Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema. *Cardiovascular System:* Hypotension, tachycardia, EKG changes. The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Serentil (mesoridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. There is no evidence that these changes are precursors of any significant disturbance of cardiac rhythm. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonos, oculogyric crises, tremor, muscular rigidity, and akinesia, occasionally persisting for several months or years especially in elderly patients with brain damage. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, weight gain, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia, behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

Dosage and Administration: ORAL: Should be adjusted to needs of the individual. Lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to maintenance level. *Schizophrenia:* For most patients, regardless of severity, starting dose of 50 mg. t.i.d. recommended. Usual optimum total daily dose range 100-400 mg. *Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome:* For most patients starting dose of 25 mg. t.i.d. recommended. Usual optimum total daily dose range 75-300 mg. *Alcoholism:* For most patients usual starting dose is 25 mg. b.i.d. Usual optimum total daily dose range 50-200 mg. *Psychoneurotic Manifestations:* For most patients usual starting dose is 10 mg. t.i.d. Usual optimum total daily dose range 30-150 mg. INJECTABLE FORM: For situations in which an intramuscular form of medication is indicated. For most patients a starting dose of 25 mg. is recommended, to be repeated in 30-60 minutes if necessary. Usual optimum total daily dose range 25-200 mg.

73-731

Before prescribing, consult package circular.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936

SANDOZ

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models— **PORTABLE FOR OFFICE AND CLINIC**



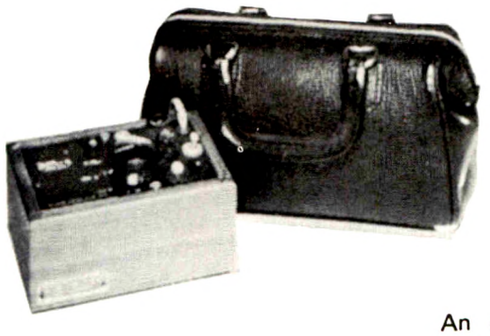
The Reiter MODEL SOS—THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives—patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes —a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

In severe anxiety

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

Please see important information on page after next.



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

from USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows...maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS

The challenge: versatility

The stereotype image of "psychiatrist and couch" is an anachronism because today's psychiatrist is called on to diagnose and treat depression in a variety of clinical settings. And when an antidepressant medication is chosen, it must be as flexible and as adaptable as the physician prescribing it.



The psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL® (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations.

The general hospital today usually provides a psychiatric unit where depressed patients are treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic, where follow-up treatment may be necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital, severely depressed patients present challenges for psychiatrist and staff alike. Here, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



The community mental health center, a remarkable innovation in the field of modern psychiatry, offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

in the treatment of depression

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps open many doors

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

addendum

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for most outpatients, who generally do well on 25 mg three times a day. This dosage may be increased to a total of 150 mg a day. Dosage increases are made preferably in the late afternoon or at bedtime. The sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be indicated whenever higher dosages are required, as for example when increases are necessary in the late afternoon or bedtime doses. It may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher dosages.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics,close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

in the treatment of clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)
helps open many doors

The

September 1973

Issue

of the

American

Journal

of

Psychiatry

Features

an

Overview Article

on

Crisis Intervention



The Special Celebration Issue

HONORING THE 80th BIRTHDAY OF

KARL MENNINGER

This special issue of the Bulletin of the Menninger Clinic will bring to the reader a group of distinguished papers written by Dr. Menninger **never before published,** together with his complete bibliography.

CONTENTS:

- Murder.
- The Psychological Advantages of the Woman Physician.
- Somatic Suicide, Total and Partial.
- Some Recollections of the Birth, Infancy, and Childhood of the American Orthopsychiatric Association.
- Fundamentalism and Modernism in Psychiatry.
- Psychological Factors in Cancer.
- On War.
- The Disappearance of Sin.

To: Bulletin of the Menninger Clinic
Box 819
Topeka, Kansas 66601

Send me _____ copies of the Birthday Issue @ $2.00 each.

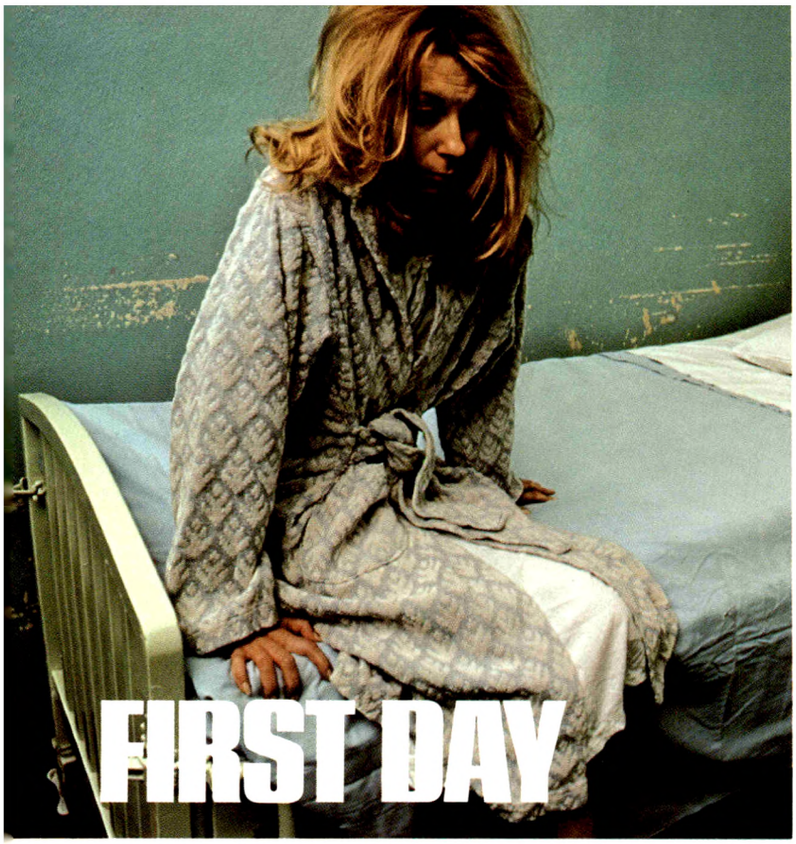
Start my subscription with the July issue @ $10.00 per year for six issues.

Please enclose check or money order.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____



First day in the hospital and all efforts will be directed toward returning her to the community.

For psychotic patients with mixed anxiety-depression, Mellaril has been found useful to help patients participate more fully in the entire therapeutic program. Continued medication with Mellaril is often basic to helping patients prepare for and participate in outpatient treatment programs that bridge the gap between hospital and community.

With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

MELLARIL®
(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic patients with mixed anxiety-depression

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.
The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage is increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

73-824 SANDOZ

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERSEY 07936

THE AMERICAN JOURNAL OF PSYCHIATRY

Social Psychiatry: An Overview

BY CAPT. RANSOM J. ARTHUR, MC, USN

Social psychiatry, which includes the study of the impingement of social phenomena upon the genesis, manifestations, and treatment of mental and physical illness, has in recent decades become an increasingly important part of psychiatry. The epidemiology and taxonomy of mental illness, social factors in the onset and course of disease, transcultural psychiatry, the hospital viewed in social terms, and community psychiatry are all fields that have shown great expansion. But the results of the experiences of community psychiatry and of social psychiatric studies have played a major role in the development of a crisis of identity within the profession of psychiatry; the appropriate education and professional activities for a psychiatrist are currently in dispute. The author discusses the impact of the rise of social psychiatry and the correspondingly great increase in knowledge of biological psychiatry on the possible future functions and education of the psychiatrist.

A COMPREHENSIVE DEFINITION of social psychiatry is difficult to formulate. Social psychiatry includes the study of the impingement of social phenomena upon the genesis and manifestations of mental and physical illness and the utilization of social forces in the treatment of mental and emotional disturbances (1). Examination of the relevant literature, including such standard journals as the *International Journal of Social Psychiatry* and *Hospital & Community Psychiatry*, indicates that the following major elements encompass the dimensions of the field: epidemiology and taxonomy, the hospital viewed in social terms, community psychiatry, social factors in the onset of disease, and transcultural psychiatry. I propose to briefly outline the major approaches and contributions inherent in each category (except in the case of social factors in disease onset and course, which will be the subject of another article) and to further speak to the problems and contradictions that have arisen in recent years.

EPIDEMIOLOGY

If there is any systematic body of knowledge underlining social psychiatry, it is epidemiology (2, 3). This science, which deals with the differential distribution of diseases and the reasons underlying these distributions, is in itself a hybrid discipline. Epidemiology depends not only on statistics but also on demography, clinical medicine, pathology, and taxonomy (4). The basic contributions of epidemiology to social psychiatry have included estimates of the incidence and prevalence of mental illness in both the hospital and community settings. Hospital census figures have been developed with sufficient care in most jurisdictions to give administrative decision makers a reasonably accurate notion of the number and type of hospitalized patients and their patient careers in terms of admission, length of stay, and readmissions. This kind of information may seem prosaic; nevertheless these data are extremely important in formulating policy on the provision of psychiatric services.

In addition, pioneering work in the field has been carried out in an attempt to gauge the prevalence of mental illness in a given community, particularly among individuals who have not been hospitalized (5–9). This work, which has been performed all over the globe, has been criticized for methodological flaws. However, the results indicate that there is a significant proportion of any population—perhaps one-fourth, perhaps one-third—that is impaired or incapacitated by psychiatric symptoms to a significant degree, although it may never receive formal psychiatric treatment. In addition to the hospital census

This paper was written at the invitation of the Editor.

Capt. Arthur is Commanding Officer of the Navy Medical Neuropsychiatric Research Unit, San Diego, Calif. 92152, and Adjunct Professor of Psychiatry, University of California School of Medicine, Los Angeles.

This work was supported by the Bureau of Medicine and Surgery, Navy Department, under Work Unit No. MF51.524.002-5011DD5G.

The views of the author do not necessarily represent those of the Department of the Navy.

UNIVERSITY COLLEGE OF MEDICINE LIBRARY O. U.

data and the field survey material, another epidemiological contribution is the work showing the differential distribution of mental disease in various social classes and the varying nature of treatment given to psychiatric patients from different social classes (10). This has had the most profound impact on the field of social psychiatry.

The cumulative effect of information indicating a vast reservoir of untreated psychiatric disease in the community and the meager treatment afforded certain elements in the population is enormous. Without this kind of information, it would have been impossible to fund and develop a series of mental health clinics in various communities. The contributions from epidemiology to social psychiatry have thus been essential. Indeed, epidemiological approaches (including operational analyses of effectiveness) are an integral part of any mental health service program today.

Having said that, one must nevertheless point out some areas of concern about the epidemiology of mental illness. The most fundamental problem remains taxonomic. There is still no universally accepted classification of mental illness and certainly no universally accepted set of diagnostic indices. The very concept of mental illness continues to be questioned, and even those who are unwilling to believe that mental illness is either myth or reification are hard pressed to feel that psychiatric diagnostic categories are valid. As long as this is so, uneasiness over the validity of psychiatric epidemiology will remain.

I think, however, that it is a mistake to be nihilistic. In the first place, there are other areas of medicine in which diagnoses (even on postmortem examination) are uncertain, and in the second place there are hopeful trends in the standardization of psychiatric diagnostic approaches, such as the joint United States–United Kingdom study of psychoses, which aims at the clarification and standardization of diagnostic observation in psychiatry (11, 12). Standardization of diagnosis does not ensure validity of diagnosis, but it is a step forward. While epidemiology is an imperfect science, it is one of the few tools we have for clarifying the influence of social factors in mental disease. Most social psychiatrists would be loath to discard it. However, it must be said that in some instances there is a subtle, sometimes inchoate, and often powerful resistance to the use of statistical analytic techniques in judging the effectiveness of certain operations, such as a mental health center. There is a feeling, not wholly without merit but often anti-intellectual in tone, that the processes of enumeration, categorization, and statistical analyses do violence to the complexity of human interactions between those who help and those who are being helped and that these statistics fail to reflect the full range of accomplishment of a given institution.

Another pejorative opinion about operational analytic statistics is that in some instances data may shape policy. For example, it is said that if a given clinic knows it must record a certain number of patient visits to maintain funding, it will shape its patient-care policy to make sure that the utilization data support the required level.

Regardless of objections, however, operational analysis of social and community psychiatric projects is a fact of life. Utilization data are a governmental requirement for all types of mental health facilities, and the evaluation of the performances of the individual clinicians as well as the effectiveness of the entire clinic will no doubt be universal before many years have passed (13). An enormous amount of work is currently being done to develop techniques and instruments for the meticulous evaluation of all phases of clinical endeavor. The instruments already devised appear to be very useful, and they will doubtlessly be followed by even more refined and intricate measuring devices. Administrators and clinicians working in all phases of medicine and most certainly in social psychiatry must expect to have their work scrutinized.

We live in an age of data and in an age when assertion unsubstantiated by evidence is nugatory. In speaking of the observations of Condorcet, the French philosopher, Sir Isaiah Berlin noted that "all real issues of the future could be decided on the basis of rational calculation of utilitarian consequences. *Calculemus* was to be the new watchword, the key to the solution both of social and of personal problems" (14). Government funds will be disbursed only to institutions that can document their usefulness. All this may seem unfortunately mechanical and rigid, but there are many rival claimants for public monies; psychiatric institutions must be prepared either to document their social utility or to perish.

SOCIAL PSYCHIATRY IN THE HOSPITAL SETTING

During and following World War II, interest in the social environment of psychiatric hospitals increased. Large mental hospitals came to be viewed as institutions that were deleterious rather than helpful to the patients confined there. The stereotypic, monotonous, and sometimes repressive atmosphere found in them was felt to increase the patients' dependency, regression, passivity, and bizarre symptoms (15). In addition to the anguished descriptions of large mental hospitals appearing in journalistic as well as scientific accounts, descriptive works examining social interactions in private mental hospitals were also published. Stanton and Schwartz (16) demonstrated how the interactional patterns by the staff members of a psychiatric hospital affected patient care. Staff conflict and disagreement, either overt or covert in character, was shown to exacerbate patients' symptoms.

In some quarters, mental hospitals came to be seen as "total institutions" sharing the characteristics of prisons, military barracks, or concentration camps (17). The patients in mental hospitals were said to be robbed of their freedom and individuality. By now there is such a plethora of sociological reports on mental hospitals that a high degree of redundancy has appeared. There are only so many things that can be said about interactions between patients, between staff members, and between patients and staff: all of these phenomena might appear to have been extensively described (18). However, Rosenhan (19) has imaginatively developed provocative new

data by the use of "pseudopatients." These pseudopatients were eight presumably sane individuals who, by alleging hallucinations, were able to gain admission to 12 different hospitals. Beyond stating that they had auditory hallucinations and falsifying their names, vocation, and employment, no false data were presented. They were nevertheless admitted to the several hospitals, whereupon they ceased simulating any signs of abnormality. In spite of their presumably sane behavior they were not detected as being normal and were hospitalized from seven to 52 days, with an average of 19 days. On discharge they were diagnosed as cases of schizophrenia in remission. In no instance were they recognized by the staff as pseudopatients. They were, however, designated so by certain regular patients in the hospitals, who recognized them as being different. A reverse study was also carried out. The hospital staff was told that at some time during the subsequent three months one or more pseudopatients would attempt admission. In fact, no pseudopatients tried to gain admission during this period; however, 41 individuals were alleged by at least one staff member to be pseudopatients. Such massive errors certainly cast doubt on the validity of psychiatric diagnosis.

These pseudopatients also studied patient-staff interaction during their incarceration. They interpreted their observations as confirming the hierarchical and compartmentalized nature of psychiatric hospitals. They particularly noted the fantastically small amount of daily contact the patients had with individual staff members, particularly the doctors. The lot of patients hospitalized in such an environment—namely, powerlessness, depersonalization, segregation from staff, and possible incorrect labeling—was felt to be overwhelmingly adverse. Of course, the average stay of 19 days was brief indeed compared to what might have happened to similar experimenters, say, in 1922 rather than in 1972.

In the last three decades a number of approaches appeared that have as their goals the transformation of the mental hospital from a custodial institution to a genuine treatment center. The most popular of these is the therapeutic community, whose fundamental idea is that the patient has potential to help not only his own rehabilitation but also the treatment of others (20, 21). The whole of the patient's time spent in the hospital is to be thought of as treatment, with the patient playing an active role in hospital management. The therapeutic community is stated to be democratic, permissive, and communal as opposed to the rigid, inflexible, and hierarchical structure of the traditional mental hospital. At present there is a multiplicity of heterogeneous programs that purport to be therapeutic communities. These range from rather traditional medical-type wards that have group therapy to wards run entirely by patients.

Such terms as "milieu therapy," "social therapy," or "administrative therapy" are occasionally used interchangeably with "therapeutic community." Indeed, certain pioneers of the therapeutic community feel that there is no one ideal formal pattern and that a number of forms are permissible, provided the general principle of patient participation in the therapeutic process is honored. In two volumes (22, 23), Marshall Edelson attempted to study social and therapeutic processes within the psychiatric hospital in a theoretical framework. His theoretical formulations rely heavily upon the social system theories of Talcott Parsons. Edelson feels that the social system within the psychiatric hospital, with its functional aspects of tensions, conflicts, and conflict resolution, must be understood and considered if one is to carry out informed psychotherapy. He outlines the interrelationships between sociotherapy and psychotherapy and attempts to fit them into a broad conceptual pattern. *The Practice of Sociotherapy* (23) speaks to the actualities of therapeutic communities and to the practical and theoretical tasks of the sociotherapist.

Edelson has made a pioneering attempt to bring theory to a field where serious theoretical formulations are few. Regardless of the validity of Parsonian functionalism in social systems, its application to psychiatric hospitals may be heuristic. There is a lamentable paucity of systematic theoretical work in social psychiatry. This exiguity stems from several sources. First, epidemiology, a major discipline within social psychiatry, may be justly regarded as refined and triumphant empiricism. Second, the sheer volume of discrete and diverse data does not lend itself to induction of general principles. And third, many of the workers in social psychiatry are antitheoretical in temperament.

Today there is a virtually universal acceptance of the basic ideas inherent in the therapeutic community: patient participation, discussion of patient-staff interaction, and greater freedom for patients than in mental hospitals in the past. In many instances the acceptance of these ideas is superficial and actual patient care is carried out in the traditional way. This is not to be regarded as necessarily reprehensible, because there is still no documentation of the specific effectiveness of the therapeutic community treatment regime. No one has denied that the enthusiasm and energy of a staff embarking upon a new approach to treatment are useful in increasing the socialization of patients, but the hard evidence proving that the therapeutic community exerts a tangible and lasting improvement in the course of mental illness is lacking (24). Rigorous research on the complex and heterogeneous variables involved in a comprehensive environmental change is extremely difficult to carry out. Nevertheless, there is consensus that mobilizing the patient's own resources is helpful in speeding his recovery and that patient care which is flexible and humane and which preserves the dignity of each patient is in the long run more beneficial than repressive and stereotyped therapy. In fact, what might broadly be called the therapeutic community approach is now the accepted method of milieu treatment, and reports of the operation of such units appear from all over the world. Warnings are sounded, however, that injudicious or mechanical applications of milieu therapy of the therapeutic community type may not always be in the best interest of specific hospitalized patients, particularly if such an approach gives rise to superficial clinical examination and erratic and overly generalized treatment plans (25).

TRANSCULTURAL PSYCHIATRY

Transcultural psychiatry has addressed itself to such questions as whether mental diseases are ubiquitous, if so, whether their incidence and prevalence vary among societies, and whether particular psychiatric syndromes are unique to a given society. Transcultural psychiatry has also addressed itself to the delineation of forces within a society that affect the incidence, prevalence, and types of psychiatric disorder (26).

It has been clearly shown that certain types of major mental illness, such as depression and schizophrenia, appear in all cultures (27–29). However, although major mental illnesses are universal, the type and form of symptoms differ markedly among groups (30). For example, although there is a core type of psychotic manifestation common to schizophrenic patients throughout the world, patients from various national groups differ from one another in the type and quality of delusions, hallucinations, motor activity, and bizarre behavior (31). Diagnostic approaches of psychiatrists from different nations are divergent at points, but diagnostic agreement by psychiatrists on major diagnostic categories is considerably better than chance. Again, work like the joint U.S.–U.K. diagnostic studies (11, 12) will be extremely helpful in the development of diagnostic approaches and criteria that are highly reliable and possibly valid as well.

In the past, a number of stereotyped psychiatric syndromes found among nonindustrialized people such as Malays, Eskimos, and American Indians were described. These syndromes appeared to have manifestations directly shaped by cultural pressure and cultural sanctions (32). As the societies in which the patients lived have changed in the direction of the Western European model, these exotic syndromes, such as latah, amok, and pibloktoq, have tended to change greatly or disappear (33).

Transcultural psychiatry at this time has documented some important truths, namely, that major mental illnesses appear everywhere among mankind but that their outward manifestations are shaped by the child-rearing practices, indoctrinations, sanctions, encouragements, and discouragements of a given culture. Much of the literature in the field now consists of reports of such phenomena as suicide in Hong Kong, psychosis in Patagonia, or depression in Nyasaland; it has proven difficult to carry out the induction of general principles from a myriad of discrete, punctate, variegated, and empirical reports. One gets the feeling of exposure to a mass of documented travelers' tales. While each report is interesting in itself, the problem of making sound generalizations from the aggregate of such papers is daunting. Each issue of *Transcultural Psychiatric Research Review* contains a section on general and theoretical issues in the field (34). This section ably and bravely attempts to bring order and generality to the disparate and often conflicting individual contributions. In addition, Kiev has recently made a superb contribution to the understanding of the nomothetic aspects of transcultural psychiatry (35). These endeavors have had some degree of success, but overriding principles and universal applications are still difficult to come by.

COMMUNITY PSYCHIATRY

Although there are some authorities who hold that community psychiatry is not a branch of social psychiatry, it can be argued that community psychiatry's explicit use of social phenomena in the understanding and treatment of mental and emotional disturbances qualifies it for the title of "social psychiatry in action" (36). An operational elucidation of community psychiatry would include the following:

1. Epidemiological studies, opinion surveys, operational analysis of community needs and resources, information programs, and education related to psychiatric problems.

2. The development, planning, organization, administration, and operation of community programs concerned with mental health. These programs would include the inauguration and operation of community psychiatric hospital services, including day treatment centers, night hospitals, outpatient clinics offering emergency services, emergency clinics, psychiatric home visits, and preventive and rehabilitative services designed to prevent individuals from either entering or reentering a mental hospital.

3. Consultations to community decision makers as well as to other agencies that provide psychiatric care. For example, in the United States, for a community mental health center to qualify for federal assistance it must offer inpatient treatment, outpatient treatment, partial hospitalization (day or night care), emergency services 24 hours a day, and consultation and education to individual and group leaders in the community. In its fullest development it must also offer diagnostic services, rehabilitation, aftercare for hospitalized patients, training for professional mental health workers and others, and research and evaluation (37, 38).

The part of community psychiatry that is most closely aligned with traditional psychiatric practice is the treatment facility in a community setting. These facilities might be attached to a preexisting hospital or they may be nonhospital in character. Such facilities include day hospitals, night hospitals, and crisis clinics. The advantages claimed for partial hospitalization include maintenance of the patient's ties to family and community as well as economic savings. The advantages of the crisis clinic are said to include the economical, prompt, and successful treatment of innumerable people who are in the midst of a severe but temporary emotional dislocation in their lives. For such people, it is felt that a brief course of highly focused treatment enables them to cope with the crisis and in so doing gain added personal strength with which to deal with future crises.

Putting together a day hospital, night hospital, rehabilitation center, emergency service, regular outpatient department, follow-up clinic, and treatment clinic for alcoholics and drug addicts into one unified facility known as

a comprehensive health center has been an explicit goal of community psychiatry for some years, and indeed the provision of such centers has been the major thrust of the federal, state, county, and municipal community psychiatry movement (39, 40). No psychiatrist can be unaware of the success of certain centers or the obvious failure of others; reports of success and failure exist in the literature (41, 42). The conflicts between expectation and actuality of results, between professional staff and community groups, and among different professional workers within these clinics have been well documented (43–46). These centers certainly function to prevent psychiatric hospitalization and to keep discharged mental hospital patients in the community (47, 48). The success of certain centers has been one of the important reasons for the declining census in mental hospitals. However, it is clear that if patients who have suffered a major mental illness are to be kept in the community and out of the hospital, a great deal of service must be provided (49).

If discharged patients are to be really helped and not merely allowed to stumble around in a psychotic trance, rehabilitative services of all types must be used. What is still unclear, however, is the extent of the adverse effects and increased family burden of having the mentally ill patient treated at home rather than in the hospital. The question of whether there are long-term, subtle deleterious effects on other family members has yet to be resolved. Another task for the future is the careful delineation of what the specific appropriate avenues of treatment are for various categories of patients (40). Unquestionably there are patients who are best treated in a psychiatric hospital or the psychiatric division of a general hospital, while others benefit maximally from partial hospitalization or treatment on an ambulatory basis in the community.

The provision of service by psychiatrists in a community mental health clinic seems to fit into the traditional professional approach of psychiatry. However, the role of the psychiatrist as a leader and model is under heavy assault from clinical psychologists, psychiatric nurses, social workers, and psychiatric technicians, who are clamoring for equal authority, equal status, and equal recompense. When we move from a clinical to the community consultation arena, even more questions arise as to the propriety and efficacy of the advice given by psychiatrists to nonmedical institutions (41, 42). Consultation to school systems and social work agencies is sufficiently within the conventional concept of the medical mission that it has widespread acceptance. Such consultation can be done skillfully or clumsily; it can be helpful or worthless but, in general, it seems an appropriate activity for a psychiatrist. When, however, the psychiatrist moves to the wider role of attempting to reorganize some sector (or even the whole) of society, then profound differences of opinion exist as to whether this is an appropriate role for a psychiatrist to fulfill.

Currently, a large body of psychiatric opinion holds that attempts by psychiatry to change portions of society are entirely appropriate and even necessary. This group feels it virtually mandatory for psychiatrists to speak to the changing of society in a way that promotes mental health. One might compare these efforts to those of pediatricians attempting to influence laws regarding the lead content of paint. While psychiatric assistance in the elimination of poverty, war, injustice, and crime is a welcome prospect, the practical difficulties of implementation prove to be daunting. Psychiatrists have found, if they move into politics, that their expert status is no longer accepted. Their advice might well be sought on the drafting of legislation dealing with health policy, but in other areas of government, such as foreign policy, they are not considered to have any a priori expertise. The legitimate question of just how their medical education and experience fit them for a political role is immediately brought up.

Those psychiatrists who enter political endeavors soon find that they must struggle along with everyone else in the political sector or they will accomplish nothing. Their words are not taken as apodictic and their ideas must contend with a thousand others and often suffer severe distortions or dislocations in the political process. The number of psychiatrists or other physicians who can make the permanent transition from the respectful atmosphere of the consultation room to the incessant struggle of politics and bureaucratic infighting is relatively small. Even the small-scale interweaving of political and medical considerations in the operation of certain community clinics has proven a demanding or even an overwhelming task for psychiatrists. In troubled areas such as ghettos there are continual and severe clashes between the professional staff of community clinics and representatives of citizens' groups; within such clinics it has been difficult to recruit psychiatric manpower. There are enormous problems of all kinds growing out of these struggles; one that has received insufficient attention is the problem of retaining good people over a period of time in such an atmosphere. It has been observed that 90 percent of the directors of psychiatric clinics in "hot spot" areas leave by the end of two years (43). If this datum is correct, then it is virtually impossible to bring any long-term plans to fruition. Institutions in which the senior staff is perpetually changing are continually beset by turbulence and gross inefficiency (45). Plans and direction are constantly changed and worthy endeavors are not brought to completion (50, 51).

Psychiatrists have so many alternative places to render service and receive professional satisfaction that it will be difficult to retain them in settings where their professional skills are denigrated and where they are subject to all manner of calumny and vilification. To be sure, certain individuals will stay on in spite of perpetual discord, but the total number turns out to be small. It might be that some form of rotation could be arranged whereby individuals committed to the same goals could alternate between the more and less stressful community clinics. It is exceedingly important, however, to provide some form of long-term continuity of local leadership. Otherwise the clinics, begun with such high hopes, will end up as dispirited institutions in which a large proportion of effort is dissipated on internal dissensions.

THE CRISIS IN PSYCHIATRIC IDENTITY

A problem of greater magnitude than the provision of psychiatrists for permanent positions in community clinics in problem areas is the question of psychiatric identity and psychiatric education. It is probable that the Zeitgeist of the last decade, which emphasized awareness of social phenomena, disillusionment with human institutions, and political activism, has enormously enhanced the expansion of social psychiatric thinking. Along with the rise of social psychiatry, consideration of social issues is increasingly prominent in psychiatry. Social psychiatry and the intellectual climate that gave rise to its flowering have struck general psychiatry with hurricane force. The past few years have witnessed a crisis within psychiatry and the growth of a feeling of nihilism, particularly marked among younger psychiatrists and psychiatric residents (52–54). Anyone who doubts the validity of this observation need only attend a meeting of professional leaders (e.g., an association of university chairmen) or talk to a group of psychiatric residents. Self-doubt, uncertain morale, and rumination abound, in sharp contrast to meetings of other medical specialists where serious problems are discussed but the basic worth of the specialty is never derogated.

Part of the motive behind this feeling of negation has been the experiences of community psychiatry in which the psychiatrist's claim to expert knowledge and skill has been severely questioned by his fellow workers. In addition, the belief that progress in preventive psychiatry can come only through political action to alter society has cast further doubt on the appropriateness and value of professional skills. At the same time, the validity of psychotherapy has been challenged by academic psychologists and behavior therapists. Many psychiatrists have had, at least to some degree, the unsettling and bewildering feeling that what they have been doing has been largely worthless and that the premises on which they have based their professional lives were partly fraudulent.

Strident and persistent voices from within the profession proclaiming the inappropriateness of a medical model of mental disease and the allegedly coercive and authoritarian methods of treatment used by many psychiatrists have also had an unsettling effect on psychiatry (55). Furthermore, splits in ideology have been detected in the psychiatric camp (56). Psychiatrists have been described as falling into three main ideological groupings: the psychotherapeutic, the somatotherapeutic, and the sociotherapeutic. In this schema the somatotherapeutic purist is presumed to think exclusively in medical models and to be disturbed by the vague definitions in social psychiatry and distressed by the single-minded activism of the partisans of the community mental health movement. The psychotherapeutic purist is said to view community mental health centers as institutions providing dilute and superficial treatment to large numbers of people without thoroughly and completely treating anyone. He also views the social theories of the genesis of mental illness as shallow, naïve, ambiguous, and unsubstantiated. If this distribution of ideological groupings within psychiatry is in any way valid, it would indicate some profound schisms within the profession. These splits must be faced up to and eventually resolved if psychiatry is to avoid the kind of fragmentation that would markedly dilute its role in health planning and vitiate its effectiveness in consultation. If psychiatry is hopelessly split internally, how can it possibly give advice to other medical or social institutions on the problems of mental illness?

PSYCHIATRIC EDUCATION IN THE FUTURE

At the same time that psychiatry has been moving into the community and into social activism, there has been a sudden pullulation of basic biological research into mental illness. The blossoming of neuroscience and psychopharmacological research has been stunning. It is already clear that one cannot intelligently read many of the articles in psychiatric journals without a detailed knowledge of neuroanatomy, neurophysiology, neurochemistry, psychogenetics, psychoendocrinology, and psychopharmacology (57–60). The 19th-century dream of a genuine rapprochement between neurology and psychiatry, which languished so long because of the lack of substantiated links between mind and brain, is now closer to realization than ever before. We may be on the threshold of a genuine neuropsychiatry. The advent of effective psychopharmacological agents and the first really successful attempts to delineate the biological substrates of disorders such as schizophrenia and depression have acted as a challenge to clinical psychopathology (61). As it has become obvious that a number of highly specific clinical syndromes exist in psychiatry and that various diagnostic and prognostic factors respond differently to various drugs, there has been a neo-Kraepelinian revival of interest in typology. A psychiatric taxonomy better than that of the past is being constructed with the use of biological, pharmacological, and computer science inputs (62). All of these developments in biological and clinical psychiatry speak to a reaffirmation of the psychiatrist as a medical specialist dealing with problems clearly in the province of medicine rather than psychology, sociology, or anthropology (63, 64). Obviously, the psychiatrist functioning as a *pur sang* medical specialist is different from a psychiatrist functioning as a social engineer. The educational implications of these developments in biological psychiatry are immediately compelling.

If one accepts the premise that psychiatry is a medical specialty, it follows that the psychiatric education which will enable the person to comprehend the advancement of medical knowledge in the next four decades must (from all present indications) include a thorough grounding in basic and clinical neurosciences as well as in clinical psychopathology and psychopharmacology (65–67). This program will differ from those of a few years ago in that no longer will neurology, neuroanatomy, neurophysiology, and neuropathology be regarded as mere hurdles to be surmounted in order to pass a certifying examination but, rather, as essential elements in the understanding of

the biological basis of clinical psychiatric phenomena such as the sleep disturbances of depression, for example. Thus psychiatry may eventually be able to provide, in a manner analogous to that of internal medicine, the pathophysiological understanding of major mental diseases. Just as congestive heart failure is explainable in terms of cardiac and renal mechanisms, so one day the clinical manifestations of unipolar and bilateral depression may be similarly explained in terms of pathoneurophysiology. The amount of time and mental discipline necessary to master these subjects must necessarily call for a restructuring of the residency curriculum and a reduction of time devoted to other topics if the training period is not to be of inordinate length. At the same time a basic knowledge of anthropology, sociology, and psychology as applied to the problems of mental and emotional illness appears of equal importance in the education of a psychiatric specialist.

Mastery of psychotherapeutic techniques still seems obligatory for the psychiatrist. Somehow the basic ideologies (somato-, socio-, and psychotherapeutic) must be reconciled in the core curriculum. It would seem that this is what every psychiatric training program in America has been trying to do for years. However, that idea is partly illusory; the actuality is that most programs have not yet faced up to the full implications of the knowledge explosion in biological psychiatry and have as yet failed to provide the very large amounts of time necessary to master these arcane and intricate subjects. Nor, on the other hand, is it clear that psychiatric training programs as a whole have given more than superficial acknowledgment to the importance of understanding certain sectors of anthropology, sociology, history, economics, and psychology. As the use of medical manpower comes under closer scrutiny by the public and its agents, there will be increasing pressure for all medical specialists (including psychiatrists) to function at their highest level of efficiency, commensurate with their long, demanding, and complex education (68). Questions are already asked as to why psychiatrists, who are so highly educated at great public and private expense over so many years, should be doing any work that could be done with equal competence by individuals, such as social workers or psychiatric aides, who have had less lengthy formal education. The question of work efficiency is also being asked of other physicians such as pediatricians, ophthalmologists, and internists.

In the future, perhaps psychiatrists and other specialists will function more in the role of consultants, directly handling only those challenging and complex cases too difficult for the primary care people to cope with. But to be a consultant one must indeed be better educated, know more, and be more competent than workers at the initial level. In addition the basic attributes of responsibility and humanity, which every good physician must possess, need to be fostered amid the exigent intellectual, emotional, and physical demands of a residency training curriculum. So many studies cited in this paper—for example, those of Rosenhan (19)—indicate professional failures at a basic human level of understanding in caring for sick patients in many environments. Serious contact between patients and staff is often minimal; patients' communications are all too often considered only superficially or ignored entirely. The studies of sociologists, not only in the field of social psychiatry but in all areas, show that human institutions are imperfect and the humans who staff them full of frailties. Psychiatrists and other physicians, who receive so many rewards in our society, have a particularly heavy obligation to be competent and humane in their care of people, regardless of the setting in which this care is given.

Status, prestige, and decision-making power conferred by ascription alone are not congruent with the egalitarian temper of modern America, and community clinics most certainly share this egalitarian spirit. If the psychiatrist is to have a leading role in important policy and therapeutic decisions and is to receive a significantly higher salary than his colleagues, he must be able to justify these perquisites by possessing knowledge and skill of a more complex kind than his fellow workers.

In the United Kingdom, most patients who visit community psychiatric installations appear, from all reports, to be well within the mainstream of psychiatry's purview —that is, to include psychotic patients, both acute and chronic in type, patients with character disorders, patients suffering from drug and alcohol intoxications, patients with organic brain disease, and even some patients with neurosis or psychosomatic disorders (69). Although there is some dispute about this, it is probable that a similar condition prevails in the United States. The character of the patient population would indicate that if a social psychiatrist is to function as a consultant specialist in such an institutional setting, he must possess a basic medical and neuropsychiatric education of the type described above. He will, of course, have had additional education (including continuing education) in social and community psychiatry per se, but he will first have had a thorough grounding in clinical and biological psychiatry (70). This education program for social psychiatrists will be similar in type to those of other subspecialists in psychiatry who wish to take further training beyond the core curriculum in, say, individual psychiatry or biological psychiatry.

Although it seems evident that a thoroughly trained psychiatrist can function most efficiently as a specialized resource within community clinics, it is less obvious that his medical education fits him for a special professional role in the general political process. Of course, a psychiatrist has the same rights and duties as any other citizen to participate in government, but I am talking about participation as an expert, not as a layman. A strong case can be made that an education that does not include medical school training but incorporates work at a school of public health in addition to the study of science, public administration, sociology, law, and economics might better equip an individual to function as a medico-political adviser to social movements than does the intense and concentrated process of medical education. Medical and psychiatric education emphasize the care of the individual patient rather than the public health or social point of

view (71, 72). One must distinguish between this public health approach and the individual point of view. In the former case the utilitarian ethic of the greatest good for the greatest number predominates, while in the latter the notion is that each individual patient should be given all the resources necessary to help him maximally, regardless of other societal demands for resources. Although some individuals can alternate these points of view as circumstances change, most people seem more comfortable with one approach than with the other.

Physicians as a whole, in spite of considerable exposure to public health considerations, tend to concentrate on individual patients. For example, physicians fail in many instances to report cases of communicable disease in spite of the importance to society of doing so. The utilitarian approach naturally characterizes the schools of public health, which most physicians (including psychiatrists) do not attend. The majority of psychiatrists prefer to work with patients individually or in groups rather than with a public health approach to psychiatric problems that emphasizes changing social and environmental conditions, which are presumed to increase the incidence of mental disease.

If those who wish to use psychiatry in a social or public health framework want to become fully trained psychiatrists first, they must necessarily subordinate themselves to an extremely rigorous, demanding, and disciplined educational process. It will not be easy for them to do this; similarly, it was not easy in the past for those primarily interested in psychotherapy to master neurosciences and neurology. Great strains are already being placed upon psychiatric education programs, and these will only increase. Future psychiatrists are often restive in the face of the rigid intellectual demands of the first two years of medical school, and now they will have to once again assimilate large masses of precisely ordered information at the beginning of their residency training. There is no easy road to the mastery of pharmacology or neuroanatomy and yet if one does not thoroughly know the actions and toxicity of psychoactive drugs or the extent and ramifications of the limbic system, how can one claim to be a psychiatric specialist? It would have been extraordinarily difficult for the just-past generations of psychiatric residents to accept this stricture.

Future generations will realize, however grudgingly, the necessity for a great deal of exacting and demanding effort to obtain the requisite knowledge. It may well be that in the future much of what is now called community mental health care in the United States will continue to be delivered by professionals who are not psychiatrists. Psychiatrists will be primarily reserved for situations that clearly demand their expert medical skills. Speculations about the future are necessarily imperfect and fraught with error, yet it seems reasonably certain that psychiatry, in a large part due to the challenges occasioned by the experiences of social and community psychiatry, must come to a knowledgeable synthesis about its definitive professional role.

Twenty years ago psychiatry was thought to be divided into two camps: the directive-organic and the analytic-psychotherapeutic. However, this was not a split at the ultimate level because both groups thought of themselves as physicians entrusted with the care of individual patients. They differed in their modes of treatment of these patients, but both groups were certain of their professional identity as medical healers. The divergence today within the profession is more profound: it is conceivable that a new profession with a social science outlook will split off from psychiatry. This new group would be nonmedical and thus free to develop its own approaches to the solution of mental health problems without the constraints of the medical tradition. Psychiatry itself would then remain within the family of medicine—not at the center, perhaps, but well within the family boundaries. Of course, elsewhere in the world, for example the United Kingdom, psychiatry has never really wavered in its conviction that it is first and foremost a part of medicine, justifying its existence by caring for sick patients, who will continue to exist in large numbers. It is probable that two decades from now the vast bulk of psychiatrists, whether they are working in a hospital or a community setting, will continue to be medical specialists using social, psychological, and biological methods of treatment in the expert and successful care of the mentally ill.

REFERENCES

1. Arthur RJ: An Introduction to Social Psychiatry. London, Penguin Books, 1971
2. Morris JN: Uses of Epidemiology. London, Livingstone, 1957
3. Pugh TF, MacMahon B: Epidemiological Findings in United States Mental Hospital Data. Boston, Little, Brown and Co, 1962
4. MacMahon B, Pugh TF: Epidemiology: Principles and Methods. Boston, Little, Brown and Co, 1970
5. Srole L, Langner TS, Michael ST, et al: Mental Health in the Metropolis: The Midtown Manhattan Study, vol 1. New York, McGraw-Hill Book Co, 1962
6. Norris V: Mental Illness in London. London, Oxford University Press, 1959
7. Leighton AH: My Name Is Legion, vol 1. New York, Basic Books, 1959
8. Hughes CC, Tremblay MA, Rapoport TN, et al: People of Cove and Woodlot, vol II. New York, Basic Books, 1960
9. Leighton DC, Harding JS, Macklin DB, et al: The Character of Danger, vol III. New York, Basic Books, 1963
10. Hollingshead AB, Redlich FC: Social stratification and psychiatric disorders. Am Sociol Rev 18:163–169, 1955
11. Cooper JE, Kendell RE, Gurland BJ, et al: Cross-national study of diagnosis of the mental disorders: some results from the first comparative investigation. Am J Psychiatry 125 (Oct suppl): 21–29, 1969
12. Psychiatric Diagnosis in New York and London: A Comparative Study of Mental Hospital Admissions, Maudsley Monographs No 20. London, Oxford University Press, 1972
13. Riedel D, Brenner MH, Brauer L, et al: Psychiatric utilization review as patient care evaluation. Am J Public Health 62:1222–1228, 1972
14. Berlin I: The bent twig. Foreign Affairs 51:11–30, 1972
15. Wing JK, Brown GW: Institutionalism and Schizophrenia. Cambridge, Cambridge University Press, 1970
16. Stanton AH, Schwartz MD: The Mental Hospital. New York, Basic Books, 1954
17. Goffman E: Asylums. New York, Aldine, 1961
18. Strauss A, Schatzman L, Bucher R, et al: Psychiatric Ideologies and Institutions. New York, Free Press, 1964
19. Rosenhan DL: On being sane in insane places. Science 179:250–

258, 1973
20. Jones M: The Therapeutic Community. New York, Basic Books, 1953
21. Jones M: Beyond the Therapeutic Community. New Haven, Yale University Press, 1968
22. Edelson M: Sociotherapy and Psychotherapy. Chicago, University of Chicago Press, 1970
23. Edelson M: The Practice of Sociotherapy. New Haven, Yale University Press, 1970
24. Zeitlyn BB: The therapeutic community: fact or fantasy. Br J Psychiatry 113:1083–1086, 1967
25. Lewis AB, Selzer M: Some neglected issues in milieu therapy. Hosp Community Psychiatry 23:293–298, 1972
26. Leighton AH: The Stirling County study: some notes on concepts and methods, in Comparative Epidemiology of the Mental Disorders. Edited by Hoch PH, Zubin J. New York, Grune & Stratton, 1961
27. Lin TY: Mental Disorders in Taiwan, Fifteen Years Later: A Preliminary Report. Geneva, Mental Health Unit, World Health Organization, 1966, pp 1–17
28. Leighton AH, Lambo TA, Hughes CC, et al: Psychiatric Disorder Among the Yoruba. New York, Cornell University Press, 1963
29. Eaton JW, Weil RJ: Culture and Mental Disorders. Glencoe, Ill, Free Press, 1955
30. Murphy HBM, Wittkower ED, Change NA: Cross-cultural inquiry into the symptomatology of depression. Transcultural Psychiatric Research 1:5–18, 1964
31. Opler MK: Cultural difference in mental disorders: an Italian and Irish contrast in the schizophrenias, USA, in Culture and Mental Health. Edited by Opler MK. New York, Macmillan Co, 1959, pp 425–442
32. Arieti S, Meth JM: Rare, unclassifiable, collective, and exotic psychotic syndromes, in American Handbook of Psychiatry. Edited by Arieti S. New York, Basic Books, 1959, pp 546–563
33. Teoh J: The changing psychopathology of Amok. Psychiatry 35:345–351, 1972
34. Murphy HBM: General and theoretical issues. Transcultural Psychiatric Research Review 9:91–104, 1972
35. Kiev A: Transcultural Psychiatry. New York, Free Press, 1972
36. Schwartz DA: Community mental health in 1972: an assessment, in Progress in Community Mental Health, vol II. Edited by Barten HH, Bellak L. New York, Grune & Stratton, 1972
37. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964
38. Sainsbury P: Social and community psychiatry. Am J Psychiatry 125:1226–1231, 1969
39. Ozarin LD, Feldman S, Spaner FE: Experience with community mental health centers. Am J Psychiatry 127:912–916, 1971
40. Wachspress M: Goals and functions of the community mental health center. Am J Psychiatry 129:187–190, 1972
41. Holden C: Community mental health centers: growing movement seeks identity. Science 174:1110–1118, 1972
42. Holden C: Community mental health centers: storefront therapy and more. Science 174:1219–1221, 1972
43. Bolman WM: Community control of the community mental health center, I: introduction. Am J Psychiatry 129:173–180, 1972
44. Bolman WM: Community control of the community mental health center, II: case examples. Am J Psychiatry 129:181–186, 1972
45. Banta HD, Fox RC: Role strains of a health care team in a poverty community. Soc Sci Med 6:697–722, 1972
46. Stubblebine, JM, Decker JB: Are urban mental health centers worth it? Am J Psychiatry 127:908–912, 1971
47. Wolford JA, Hitchcock J, Ellison DL, et al: The effect on state hospitalization of a community mental health/mental retardation center. Am J Psychiatry 129:202–206, 1972
48. Martin M: Community mental health centers: coming to grips with big ideas. Am J Psychiatry 129:211–213, 1972
49. Grad JC, Sainsbury P: Problems of caring for the mentally ill at home. Proc R Soc Med 59:21–25, 1966
50. Arthur RJ: Prevention of "future shock." N Engl J Med 287:311–312, 1972
51. Glasscote RM: The mental health center: portents and prospects. Am J Psychiatry 127:940–941, 1971
52. Brill NQ: Future of psychiatry in a changing world. Read at the 19th annual meeting of the Academy of Psychosomatic Medicine, San Diego, Calif, Oct 29–Nov 1, 1972
53. Agel J: The Radical Therapist: The Radical Therapist Collective. New York, Ballantine, 1971
54. Agel J: Rough Times: The Rough Times Staff. New York, Ballantine, 1973
55. Szasz TS: The Myth of Mental Illness. New York, Hoeber-Harper, 1961
56. Sabshin M: The anti-community health "movement." Am J Psychiatry 125:1005–1012, 1969
57. Snyder SH: Catecholamines in the brain as mediators of amphetamine psychosis. Arch Gen Psychiatry 27:169–179, 1972
58. Wender PH: Genetics and schizophrenia. JAMA 223:1382–1383, 1973
59. Bunney WE, Goodwin FK, Murphy DL, et al: The "switch process" in manic-depressive illness, II: relationship to catecholamines, REM sleep, and drugs. Arch Gen Psychiatry 27:304–309, 1972
60. Bunney WE, Goodwin FK, Murphy DL: The "switch process" in manic-depressive illness, III: theoretical implications. Arch Gen Psychiatry 27:312–317, 1972
61. Rees WL: New horizons in psychopharmacology. Proc R Soc Med 65:813–818, 1972
62. Beigel A, Murphy DL: Assessing clinical characteristics of the manic state. Am J Psychiatry 128:688–694, 1971
63. Goldberg D: The scope and limits of community psychiatry, in The Role of Community Psychiatry. Modern Problems of Pharmacopsychiatry, vol 6. Edited by Shagass C. Basel, Karger, 1971, pp 5–25
64. Akiskal, HS, McKinney WT: Psychiatry and pseudopsychiatry. Arch Gen Psychiatry 28:367–373, 1973
65. Clare AW: Training of psychiatrists. Lancet 2:753–756, 1972
66. Russell GFM, Walton HJ: The Training of Psychiatrists. Proceedings of the Conference on Postgraduate Psychiatric Education, March 6–8, 1969. British Journal of Psychiatry Special Publication No 5. Ashford, England, Royal Medical-Psychological Association, 1970
67. West LJ: The future of psychiatric education. Am J Psychiatry 130:521–528, 1973
68. Battistella RM: Rationalization of health services: political and social assumptions. International Journal of Health Services 2:331–348, 1972
69. Sainsbury P, Grad JC: Evaluating the community psychiatric service in Chichester: results. Milbank Memorial Fund Quarterly 44 (Part 2): 246–278, 1966
70. Rittelmeyer LF, Kvarnes RG, Schneider I: Continuing education for community psychiatry. Am J Psychiatry 129:578–582, 1972
71. Hobbs N: Mental health's third revolution. Am J Orthopsychiatry 34:823–833, 1964
72. Eisenberg L: Developments in psychiatric postgraduate training in the United States. Soc Sci Med 7:99–102, 1973

Reentry: II. "Making It" Back in the States

BY JONATHAN F. BORUS, M.D.

The author defines the differential characteristics, adjustment stresses, and coping methods of three groups of successful and unsuccessful Viet Nam veterans attempting to "make it" back in the States. His findings suggest the need for preventive intervention programs to facilitate the successful readjustment of these veterans. Such programs should focus on decreasing unnecessary stresses in the readjustment process, better preparing returnees for adjustment issues, and increasing the variety of coping methods available to them.

WITH LITTLE PUBLIC or professional notice, three million Viet Nam veterans have undergone the reentry process of returning from a combat zone to life in the States. For most veterans the initial readjustment period has occurred while they were completing their active duty military obligation at a garrison Army post in the continental United States. The following data derive from an interview study, at one such garrison post, of veterans' adjustment within the first seven months after their return from Viet Nam. This study attempts to define the characteristics, adjustment stresses, and coping methods that differentiate those successfully readjusting returnees who are "making it" back in the States from those veterans who have had severe difficulties in the readjustment process.

METHOD

A stratified sample of 64 men who had served in Viet Nam between June 1969 and December 1970 was selected for interview from a total study population of all first-tour enlisted men entering an east coast garrison unit. The interviewees had reported to the garrison unit immediately after their one-month post-Viet Nam leave. They were selected for interview according to the nature of their readjustment and were divided into three study groups. The veterans in Group A were adjusting well, or making it on return, while the soldiers in Groups B and C showed indices of maladjustment, of not making it.

Group A (N = 22) consisted of soldiers who were making it on return as evidenced by their neither receiving punishment for disciplinary-legal difficulties nor being referred to the mental hygiene consultation service for emotional problems. Each Group A soldier was matched to a maladjusting soldier in Group B or C for exposure to the same military milieu (living in the same company during the same period of time). Group B (N = 22) consisted of soldiers who since their return had had disciplinary-legal difficulties (e.g., getting into fights or being absent without leave) for which they had received nonjudicial punishment in the garrison unit. Group C (N = 20) consisted of soldiers who since their return had experienced emotional difficulties (e.g., recurrent nightmares, interpersonal withdrawal, or belligerence) that prompted self-referral or command referral of the soldier to the post's mental hygiene consultation service. The soldiers in Groups B and C were selected to be interviewed as the Army index of their maladjustment (the record of their nonjudicial punishment or mental hygiene referral) was noted in the ongoing study of the larger unit population. Each veteran was seen anonymously in a two- to two-and-one-half-hour semi-structured individual interview during the first seven months after his return to this country.

FINDINGS

Demographic Characteristics

Table 1 shows that four demographic variables, all related to past and present coping success, retrospectively differentiate the three groups. Compared to the maladjusting soldiers in the other two groups, the Group A soldiers were significantly better educated, held higher rank, were older, and were most frequently drafted into service. The former two variables indicate the achievements of Group A soldiers in coping with the stresses of complex educational and military institutions, while the latter two variables indicate their success in finding and holding the job or schooling from which they were drafted at an "advanced" age. Group B soldiers, with disciplinary-legal readjustment problems, had the lowest past educational

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

At the time this work was done Dr. Borus was Research Psychiatrist, Department of Psychiatry, Walter Reed Army Institute of Research, Washington, D.C. He is now with the Erich Lindemann Mental Health Center, Boston, Mass., and is Assistant Professor of Psychiatry, Harvard Medical School. Address reprint requests to Dr. Borus, Outpatient Clinic, Erich Lindemann Mental Health Center, Government Center, Boston, Mass. 02114.

The author wishes to thank Col. Harry C. Holloway, MC, USA, and Dr. David H. Marlowe for their assistance throughout the research project and Mr. Albert F. Dowd and Ms. Helen A. Dallman for their assistance in data collection and manuscript preparation.

The opinions expressed herein are those of the author and do not necessarily reflect the views of the Department of the Army or the Department of Defense.

achievement level and worst present military achievement level, which suggests their difficulties in coping with large institutions. That Group C soldiers, with emotional problems, were the youngest volunteers for enlistment suggests that these soldiers tended to deal with problems by trying to escape to new situations.

Adjustment Issues

As delineated in a previous paper (1), the immediate adjustment stresses facing the Viet Nam combat veteran fall into the four categories of military, family, social, and emotional adjustment issues. What follows is a profile comparison of the differential effects of these adjustment stresses on the three study groups of returnees.

Group A. The soldiers in Group A experienced little difficulty in coping with the stresses of readjustment. The returnees in all three study groups disliked having to serve additional duty after returning from combat and felt that garrison life did not provide a meaningful military mission, small unit group support to promote institutional affiliation, or fair, predictable leadership that motivated ready performance of Army tasks. However, unlike their maladjusting cohorts, Group A soldiers did not feel that the frustrations of garrison life were particularly unfair or purposely harassing; they saw the military demands, rules, and discipline of the garrison as expectable and understandable in terms of their knowledge of, and past success in coping with, complex institutional systems. They also could best tolerate the frustrations of garrison life because they were most adept at getting the institution to meet their needs.

Group A soldiers experienced only mild and temporary disequilibrium in readjusting to their family situations. Only 18 percent reported encountering severe family problems or disruptions during their initial 30-day post-Viet Nam leave. In addition, the soldiers in this group experienced the least conflict in coordinating the demands of their families and the Army after returning to active duty.

Group A soldiers, like those in the other two groups, had worked out definite positions on the social issues of adjustment, and there was surprisingly little difference in the way the three groups felt about the war, the organized antiwar protest movement, and the deteriorated racial situation in the United States. Group A soldiers, however, invariably denied feeling guilty about their participation in the war or let down by an "uncaring society" on their return.

They also felt the least changed by their Viet Nam experience, and those who did feel changed (50 percent) perceived the changes as being beneficial, e.g., "I gained a greater appreciation of life in Viet Nam." They had the least difficulty expressing their feelings, experienced few nightmares or disturbing thoughts about Viet Nam, and had the least trouble sublimating violent affects and controlling violent behavior. Dealing with drug habits was not a major problem for them because their use of drugs in Viet Nam and on their return had been significantly less than that of the maladjusting returnees. Group A soldiers' total drug experience was essentially limited to experimentation with marijuana while in Viet Nam; none had used opiates at any time, and only one continued to smoke marijuana after his return.

TABLE 1
Demographic Characteristics

Group	N	Mean Age* (Years)	Enlisted** (Percent)	High School Graduate** (Percent)	Mean Rank* (Grade)
Group A	22	21.7	37	77	4.50
Group B	22	20.8	55	41	3.55
Group C	20	20.6	60	60	4.05

*Difference between Group A and Groups B and C is significant at $p<.01$ level (t test).
**Difference between Group A and Groups B and C is significant at $p<.05$ level (chi-square).

Group B. The Group B soldiers, who had encountered disciplinary-legal problems, had the most difficulty adjusting to institutional Army life. The successful completion of the 12-month combat tour had been one of their major adjustment achievements, and they were quite disappointed with the low status accorded them as combat veterans in the garrison. They missed the intense combat unit relationships that had supported their satisfactory functioning in Viet Nam and had, on their return, replaced these mission-syntonic relationships with friendships whose uniting bond was hatred of the Army. They felt that the military system was purposely harassing them with the tighter discipline and bureaucratic frustrations of garrison life. In congruence with their past lack of success in complex institutions, they did not understand the structure, expectations, or rules of garrison life and did not know how to subtly manipulate the Army to get what they wanted out of it. Instead, they often reacted in impulsive, institution-confronting ways, provoking negative sanctions that only increased their frustration.

Group B soldiers were intermediate between the other two groups in the stressfulness of their family readjustment. Thirty-five percent of them encountered serious family problems on their return. These problems were most often reported to be due to family unreliability rather than to a returnee's interactional difficulties, e.g., several soldiers returned to receive "Dear John" responses from girl friends who had been repeatedly unfaithful; another found on return that his family had spent all of the money he had saved for college and sent home for safekeeping.

Almost all of the Group B soldiers (88 percent) felt that their Viet Nam experience had changed them in a significant way, with a slight majority feeling that the change was a good one. However, they characteristically reported trying to compartmentalize the Viet Nam experience or to block it out of their minds, e.g., "It's over and I never think about it anymore." Forty percent described overt difficulty in expressing their feelings to others since their return, while the remainder usually talked only

about the "pleasant parts" of their Viet Nam tour. They reported few recurrent nightmares, and although some found themselves more irritable, they felt their never-too-reliable control over impulsive behavior had not changed significantly on their return.

Group B soldiers did not report control of drug use as a major readjustment concern, and none was in legal difficulty with the Army specifically because of drug use. They had experimented with many drugs, but their regular drug use was not as great as that of Group C. Even though almost 20 percent of Group B soldiers had regularly used opiates and 60 percent had used marijuana regularly in Viet Nam, on return none continued to use opiates and regular marijuana smoking dropped below 25 percent.

Group C. As expected, Group C soldiers reported that interpersonal and intrapsychic emotional difficulties colored most of their readjustment efforts. They also disliked continued Army duty, but unlike their cohorts in the other two groups, they saw the frustrations of garrison life as personally directed against them. They had severe difficulty dealing with the personal transactions of military life, were least successful in forming supportive friendships in the garrison, and felt, more strongly than the cultural norm, that the "lifers" were out to get them. Their characteristic pattern of seclusive noncommunication at times gave way to explosive behavior that rapidly prompted their referral to the mental hygiene clinic.

Reentering the family situation was most difficult for Group C soldiers, 65 percent of whom faced severe family disruptions during their post-Viet Nam leave. These family problems were frequently intertwined with the veterans' difficulties in interacting effectively with family members, e.g., there were numerous examples of disruptive fighting with, or withdrawal from, a wife or girl friend on return. Most of the Group C soldiers reported that continued Army service conflictually separated them from wives, children, parents, or others who exerted strong demands for their emotional and/or financial support.

Group C contained the most soldiers who felt guilty about their activities in Viet Nam (about 25 percent of the group); this guilt often stemmed from experiences of killing in the line of duty. They also were the most upset with their treatment by society on return, 35 percent feeling that no one cared about their service or that people thought them suckers for going to Viet Nam and killers on return.

Almost all of the Group C soldiers (85 percent) saw themselves as changed by Viet Nam in a damaging way, including "shot nerves," short tempers, and belligerent or isolated interpersonal relationships. They found it most difficult to talk about their experiences in Viet Nam, fearing exacerbation of upsetting memories or feelings. Group C soldiers were most haunted with recurrent nightmares and disturbing obtrusive thoughts about death and maiming in Viet Nam, found themselves most irritable in interpersonal situations on return, and had the greatest difficulty controlling violent behavior.

They also had the highest frequency of regular use of drugs in Viet Nam and on return. Forty percent had used opiates regularly in Viet Nam, and two soldiers in this group were the only veterans who continued regular opiate use on return. Regular marijuana use in Group C reached 80 percent in Viet Nam and was continued by 40 percent of the soldiers on return. Although their conspicuous drug use prompted some of the initial referrals to the mental hygiene clinic, the Group C soldiers felt that their drug use was symptomatic of more basic interpersonal and emotional problems. Many related drug or alcohol abuse on return as a pharmacological escape from painful feelings and difficult readjustment situations.

Differential Coping Methods

Methods for anxiety containment, self-esteem maintenance, and continued task performance are necessary in coping with stressful transition periods (2, 3). In studying the reentry transition of the Viet Nam veteran, it is important to see if each study group's specific coping methods can be delineated, in order that useful information about coping may be abstracted for transfer to maladjusting soldiers in an intervention program.

The soldiers of Group A were by both personal and institutional assessments the most successful copers in this transition. They adaptively used the following variety of coping methods in dealing with the various stresses of return:

1. They built on their past histories of adjustment success to enable satisfactory task performance. "I do my job like I always have, I make it here by instinct."
2. They utilized interpersonal relationships with relatives and peers to verbally work through Viet Nam and reentry experiences.
3. They contained anxiety sufficiently to be able to consider long-range unfavorable consequences of impulsive acts and delay them. "I stay out of trouble because I plan to use the GI Bill at school."
4. They used their experiences with, and knowledge of, the functioning of complex institutions to learn to navigate the Army system in an effective way without threatening their self-esteem. They saw the stresses of the garrison post, i.e., the details, guard duty, etc., not as harassment personally directed against them but as an understandable, although unpleasant, part of a bureaucratic system.
5. They used their knowledge of institutions to get what they wanted out of the Army. They understood the self-defeating consequences of needlessly confronting the system and knew how to appropriately use both formal and informal communication channels. If a Group A soldier wanted to go on a weekend pass, he knew *both* how to formally request it in a way most likely to get a favorable response *and* how to informally take it without being marked "absent without leave" if formal permission was not likely to be given.

In sum, the Group A soldiers were best able to contain anxiety and maintain self-esteem during the transition period while accomplishing institutional and personal ad-

justment tasks to the benefit and up to the standards of themselves and the Army.

Group B, the maladjusting soldiers with disciplinary-legal problems, were intermediate between Groups A and C in having a greater variety of coping behaviors than Group C, but meeting with less success in the coping process than Group A, as follows:

1. Denial of feelings was prominent in many Group B soldiers. They tightly defended against anxiety by denying awareness of many of the emotionally stressful issues that Group A soldiers handled well and Group C soldiers tried to escape.

2. They acted out under stress as opposed to dealing with conflict internally. This was demonstrated in the often impulsive behaviors that caused their disciplinary-legal problems, e.g., going absent without leave or getting into fights.

3. More adaptively, they tried to keep occupied and physically active at all times as another way of dealing with feelings through action. "I work a second job to keep my mind off my problems and off the Army."

4. Characteristically, the Group B soldier did not understand the functioning of complex institutional systems and had a history of difficulty in coping successfully with them. He felt harassed by the military stresses of garrison life, and he tried to cope with his lack of functional understanding by projecting all of his readjustment difficulties onto the Army and enlisting peer support for his hatred of the system.

5. Unlike the Group A soldier, the Group B soldier did not understand the differentiation and subtleties of the Army's formal and informal communication networks and did not know how to manipulate them to his own benefit. He invariably got caught if he violated a rule because he did not understand the system sufficiently to use the proper timing or approach.

In sum, Group B soldiers contained anxiety and tried to maintain self-esteem by denying internal readjustment stresses or expressing them in action. They relied on outside authorities (the family and/or the Army) to keep them in line, with variable task performance that, on at least one occasion, was unsatisfactory to the Army.

Group C, the maladjusting soldiers with emotional difficulties, were the least successful copers. They used the following limited number of coping behaviors, all centering around avoidance:

1. These soldiers had great difficulty containing their anxiety and tried to escape the stress of the transition situation rather than actively coping with it. "I take drugs to get out of the Army and make time pass."

2. Their anxiety was heightened by interpersonal contact, and they withdrew or avoided others. "I'm afraid I'll lose control so I walk away from people."

3. In a somewhat paranoid fashion, many saw the stresses of garrison life as personally directed against them by individuals in power (lifers). In general, they did not see the stresses of garrison life as expectable or in the perspective of long-range plans.

4. They used their knowledge of institutional functioning to attempt to manipulate the system to escape. "When I'm told to do what I don't want to do, I go to Mental Hygiene and get a sick slip."

5. As a cry for help, some confronted the system with conspicuously inappropriate drug use, violence, or despair to provoke referral to the mental hygiene clinic.

6. Most adaptively, some returnees actively sought help. "I went to Mental Hygiene to talk out my problems and learn how to deal with them in a better way."

In sum, Group C's unsuccessful coping behaviors centered around avoidance and neither contained anxiety nor maintained self-esteem to allow success in task accomplishment.

DISCUSSION

The findings suggest that the successfully adjusting returnee can be retrospectively differentiated from his less successful cohorts by demographic differences that attest to his past adjustment success, by a less stressful transition experience due to his better preparedness for and understanding of the readjustment issues, and by his use of a variety of secondary process coping methods that allow both emotional conflict resolution and satisfactory functioning. There are two ways individuals and institutions can interpret and react to these data.

A first interpretation can be used to justify continuation of the present procedure of "labeling" and "disposing" of returnees. To proponents of this process, the data confirm their labeling of the Group A soldiers as "good apples" who are basically "made of better stuff" that has sustained them in past crises and in the present transition. Similarly, the data can be used to support the converse labeling of maladjusting soldiers as "rotten apples" who have not been able to make it in past crises or in the present transition due to basic character defects. The derogatory sublabels of "impulsive," "sociopathic," or the favorite Army term "character and behavior disorder" are given to the Group B soldiers, while "psychotic," "emotionally unstable," or "addict" are frequently appended to Group C labels.

The corollary action to such labeling is often the disposing process of extruding those with the most severe readjustment difficulties from the service as unfit and tolerating the mildly maladjusting without active intervention until they are also disposed of through discharge. This disposing process ignores the human and institutional waste and inefficiency of not developing programs to foster healthy readjustment in these returnees. I believe this is another example of the too-often invoked "Heads I win, tails you lose" philosophy of practice in garrison military psychiatry, which *simultaneously* posits social system structure as the essential cause of adequate functioning and individual personality defect as the essential cause of malfunctioning (4).

A second way of interpreting and reacting to these data would more adequately fulfill our society's obligation to its Viet Nam veterans. This interpretation discredits the rotten apple thesis by noting that the presently maladjusting returnees have performed well in other stressful

situations in the military when the social system was specifically structured to promote adjustment and functioning, e.g., basic training or the Viet Nam combat experience itself. If proper social system structure is a support to adequate functioning, then defects in the social system of the garrison should be sought to understand and correct malfunctioning in the Viet Nam veteran. This interpretation leads to a more fruitful application in the garrison of military psychiatric principles, proven effective in combat, which explore possible ways to influence the social structure to decrease unnecessary stresses and increase the supporting systems that can sustain men in transition (5–7).

It also fits well with social psychiatric theory that describes crisis situations, such as the reentry transition, as times of emotional imbalance when minimal interventions may have great effectiveness in encouraging growth of coping repertoires for successful adjustments (8, 9). Since there is little in the demographic data that can be used prospectively to define a target population at greatest risk for reentry difficulty, primary prevention programs to foster successful readjustment in the greatest number of returnees should be designed, implemented, and evaluated. Such intervention programs should focus on decreasing unnecessary stresses in the readjustment process, better preparing returnees for expectable adjustment issues, and increasing the variety and applicability of the coping methods available to returning veterans.

The following basic elements should therefore be included in the design of primary prevention programs within the military to foster healthy coping on reentry:

1. Such programs should alert the returnee to the military, family, social, and emotional stresses he should expect to encounter during the reentry transition in order to help him prepare for and gain perspective on these issues.

2. They should stimulate military institutions to decrease unnecessary stresses during the transition period and design supporting systems (useful missions, group supports, respected leadership) into the social structure of continued military service in the garrison.

3. They should help the returnee understand the formal and informal functioning of large institutional systems, as exemplified by the Army, and suggest methods of working within the system that facilitate self- and institutional satisfaction.

4. They should provide settings in which the veteran can avoid isolation and gain group support from other veterans for conflict resolution through examination, expression, and sharing of feelings and experiences about Viet Nam and the reentry process.

5. They should provide early recognition and offer rapid professional help to the minority of returnees with severe emotional and interpersonal difficulties that cannot be overcome without intensive therapy.

An intervention model elaborated on these basic elements is presented in another paper (10).

REFERENCES

1. Borus JF: Reentry, I: adjustment issues facing the Vietnam returnee. Arch Gen Psychiatry 28:501–506, 1973
2. Coelho GV, Hamburg DA, Murphy EB: Coping strategies in a new learning environment: a study of American college freshmen. Arch Gen Psychiatry 9:433–443, 1963
3. Coelho GV, Silber E, Hamburg DA: Use of student TAT to assess coping behavior in hospitalized, normal, and exceptionally competent college freshmen. Percept Mot Skills 14:355–365, 1962
4. Atkinson RM: Ineffective personnel in military service: a critique of concepts and rehabilitation practices from a psychiatric viewpoint. Am J Psychiatry 127:1612–1618, 1971
5. Glass AJ: Observations upon the epidemiology of mental illness in troops during warfare, in Symposium on Preventive and Social Psychiatry. Washington, DC, US Government Printing Office, 1957, pp 185–198
6. Bushard BL: The US Army's mental hygiene consultation service. Ibid, pp 431–444
7. Hausman W, Rioch DM: Military psychiatry: a prototype of social and preventive psychiatry in the US. Arch Gen Psychiatry 16:727–739, 1967
8. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964
9. Tyhurst JS: The role of transition states—including disasters—in mental illness, in Symposium on Preventive and Social Psychiatry. Washington, DC, US Government Printing Office, 1957, pp 149–169
10. Borus JF: Reentry, III: facilitating healthy readjustment in Vietnam veterans. Psychiatry (in press)

Acupunctural Analgesia: Its Explanation by Conditioning Theory, Autogenic Training, and Hypnosis

BY WILLIAM S. KROGER, M.D.

Acupunctural analgesia seems to work—but better for the Chinese than for other nationalities. Significant antecedent, intervening, and dependent variables indicate that the technique can best be understood within the paradigm of contemporary conditioning theory. It has not been placed in this framework because scientist-observers have not stressed the effects of shaping and modifying behavior by a kind of operant conditioning that brings about compliant behavior without the necessity for overt cooperation. This compliance can account for the broad spectrum of psychobiologic experiences leading to well-known placebo responses. Another factor not generally recognized is the powerful effect of suggestion, which enhances suggestibility and hypnotizability. The author also discusses the neuropsychophysiologic mechanisms involved in acupunctural analgesia.

ONE OF THE OLDEST MEDICAL TEXTS in existence is *The Yellow Emperor's Classic of Internal Medicine* (1) (*Huang Ti Nei-Ching Su Wen*). Presented as a dialogue between the legendary Huang Ti, the third of China's emperors, and his minister Ch'i Po, its system of therapeutics has had a profound influence on medicine and psychotherapy as practiced throughout Asia. Much of the text's anatomical-philosophical-physiological belief systems survive today, finding their expression in the healing methods of moxa (moxibustion or ignipuncture) and acupuncture, the latter a subject of current controversy. Faith in the therapeutic value of moxa and acupuncture is closely related to the Chinese cosmogony, involving the creation of the universe and the maintenance of its and the organism's equilibrium—the all-important yin and yang.

The ancient system of acupuncture therapy consisted of piercing one of the 12 channels or meridians (representing months) at one or more of the 365 points (representing days); each site represents a specifically diseased organ. The puncturing purportedly allowed evil air causing stagnation of the blood to escape, thus reestablishing normal circulation. Appropriate atmospheric conditions, position of the moon, insertion and withdrawal of the needle consonant with inhalation, twisting, and exhalation were part of the regimen. A strong belief still persists among some members of the Chinese medical profession as to the validity of yin and yang—a concept similar to homeostasis.

Now, after more than 3,000 years and as the result of Mao Tse-tung's New Thought Directives, Chinese traditional medicine (consisting of love, herbs, and acupuncture) has been combined with Western or modern medicine to improve the delivery of health care services for over 850,000,000 Chinese. Dimond, in two detailed reports (2, 3), described the use of acupuncture for medical, psychiatric, and surgical conditions. Regarding the former two, he stated: "A great deal of it [acupuncture] is plain psychotherapy for psychosomatic complaints." However, he and others who have observed acupuncture in China (4), as well as the more than 1,000,000 acupuncturists who use it worldwide, cannot explain its modus operandi, especially for acupunctural analgesia.

NEUROPHYSIOLOGIC FORMULATIONS

The thrust of this article will be to present a rational explanation only for acupunctural analgesia; I will not discuss the use of acupuncture for other medical applications. The current theoretical and clinical research on acupunctural analgesia, coupled with my own formulations, will be presented to clarify what unquestionably is a valuable technique. These hypotheses are based on my many years of performing relatively painless major and minor obstetrical and surgical procedures with what was called (for want of a better name) hypnoanesthesia. It should be emphasized that my bias as a non-Oriental scientist-observer, however detached I may be, may affect the validity of my observations. With these limitations in mind, I shall present my evaluations of acupunctural analgesia as viewed from the framework of Western medicine.

Dimond (3) mentioned two schools of thought: 1) the existence of a possible neural pathway and 2) the involvement of the traditional meridians as described in the ancient charts and manikins. Regarding the first, Chou Kuang-han, according to Dimond (3, p. 1563), noted that procaine injected at the acupuncture site did not produce anesthesia at a distant point. However, when widely injected around the acupuncture site, it did block the distant anesthetizing effect even though there was no correlation with segmental neural pathways.

Bong-han (5, p. 172) used radioactive tracers and mi-

Read at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Kroger is Executive Director, Institute for Comprehensive Medicine, 9735 Wilshire Blvd., Beverly Hills, Calif. 90212.

crodissection techniques to identify channels corresponding to the classical meridians. His data could not be confirmed; it is believed that he simply discovered the lymphatic system. Another group (3, p. 1563) demonstrated a reduced cerebral "induction voltage" in rabbits even though painful stimulation was continued from the periphery. Chow Chung-fo and Li Chao-te (3, p. 1563), on the basis of histological preparations, described groups of vagus nerve endings in the pinna of the ear. When stimulated, these changed the "electrical resistance" over the abdomen. After reviewing the above data, Dimond concluded that "the existence of a neural pathway has not been proved but is suggested" (3). Western anatomists have not consensually validated the findings mentioned above, nor have they substantiated any relationship of meridians and points to the production of acupunctural analgesia.

Matsumoto (6) studied pain relief by acupuncture in Japan. He favored abandoning the traditional Chinese explanations of how it works for the spinal "gate control" theory first proposed by Melzack and Wall (7), both of whom were concerned with the general mechanisms of pain rather than with acupuncture.

THE SPINAL AND THALAMIC "GATE CONTROL" THEORIES

Melzack and Wall stated in a later publication (8): "Stimulation of the skin evokes nerve impulses that are transmitted to three spinal cord systems: the cells of the substantia gelatinosa in the dorsal horn, the dorsal column fibers that project toward the brain, and the central transmission (T) cells in the dorsal horn."

They proposed that:

> 1) the substantia gelatinosa functions as a gate control mechanism that modulates the afferent patterns before they influence the T cells; 2) the afferent patterns in the dorsal column act, in part at least, as a central control trigger which activates selective brain processes that then influence, by way of descending fibers, the modulating properties of the gate control system; 3) the T cells activate neural mechanisms which comprise the action system responsible for perception and response. The theory suggests that pain phenomena are determined by interactions among these three systems.

These neurophysiological formulations may explain sensations from the periphery of the body and skin. However, they do not explain how pain from traction of the large abdominal muscles or peritoneal tissues or the periosteal discomfort commonly encountered in chest surgery are blocked.

Fox (9, p. 12), an advocate of the gate theory, stated: "Sensation from deep-pressure receptors or stimulation at certain frequencies produce stimuli that are selectively carried by the larger myelinated A-delta nerve fibers. When these impulses reach the spinal cord, this closes the gate and inhibits the upward transmission of pain."

Man and Chen (10) questioned one role of the gate hypothesis, noting that it fails to explain why acupuncture needles placed in the face or neck should block pain, since the substantia gelatinosa ends in the medulla.[1] They posited a second gate in the thalamus on the basis that the A-beta fibers, besides sending branches via the dorsal column to the segments above, also send branches to the nuclei gracilis and cunneatus, where the impulses are relayed to the ventral posterolateral nucleus of the thalamus, causing the thalamus gate also to be closed. They also stated that A-beta fibers are found in all peripheral nerves.

Melzack (9, p. 13) then postulated a two-gate theory but placed a "central biasing mechanism" in the lower brain stem, claiming that the evidence does not support a thalamic location. Wald (12, p. 17) noted that Chang Hsiang-tung and his associates at the Shanghai Academy of Sciences found that at least four gates control and channel pain impulses.

Wald stated that this group has been studying a special nucleus of the thalamus called the *centre mediant parafascicular*, referred to as the CM-PF complex in the medial thalamus. There is a high concentration of pain-receiving cells here, which the researchers impale individually on a microelectrode. Characteristic electrical responses are identified as pain. They demonstrate suppression of pain responses by stimulating large sensory nerves; such stimulation anywhere in the body tends to lower pain all over. Wald added that "the strongest effect is achieved when the needle impulses are feeding in about the same spinal cord levels as pain impulses from the area you are trying to anesthetize" (12, p. 17).

In another report (13), Wald stated that "inhibition of the small pain-carrying fibers by the large fibers happens at *all* levels of the central nervous system: in the spinal cord, the brain stem, the thalamus and the cerebral cortex. ... For example, to kill pain in the jaw region a needle will be placed at a point between the thumb and first finger. The reason is that the nerve fibers stimulated in the hand lead into the spinal cord at the same spot that pain-carrying fibers from the jaw join the cord" (13).

Melzack (9, p. 12) also claimed that stimulation of the peripheral nerves in these areas (hand and jaw) could activate the central biasing mechanism (close the gate) in the brain stem, not the thalamus.

If Chang's elegant experiments and observations are corroborated, might not these mechanisms also explain the blocking of pain by the conditioned inhibition characterizing hypnosis and other suggestive procedures? Can such experimental data from animals be extrapolated to humans, who function at far more complex perceptual and cognitive levels, particularly in regard to pain reception?

To further refute traditional concepts, Man and Chen (10) and some Cantonese surgeons (9, p. 12) ignored the classic meridians and acupuncture points. They

[1] P. D. Wall has stated (11) that the substantia gelatinosa does not end in the spinal cord; the trigeminal nerve nucleus has a clear analogue of the substantia gelatinosa. Further, he said that each stage of transmission would have a gate, even though he and Melzack concentrated on the first central synapses.

anesthetized any sector by inserting needles randomly on the body surface; the only stipulation was that the needles had to "hit the peripheral nerve." Similar results have been obtained with electrically stimulated needles, a recent innovation (10). When they were "jiggled" or electrically driven, usually some numbness and throbbing occurred. Such strong distractions act as misdirection of attention and inhibit pain inputs from the operative site reaching the cortex. This conditioned transmarginal or "partial neural inhibition" (14–16) automatically raises the pain threshold. Such competition for signal inputs follows the principle of dominant effect; a strong conditioned signal supersedes a weak one.

Most proponents of acupunctural analgesia use the spinal gate theory as supportive evidence. But Melzack and Wall (8) acknowledged its deficiencies. They stated:

> The various specific theoretical mechanisms . . . fail to comprise a satisfactory theory of pain . . . . The evidence permits only a loose association of function with fiber diameter. . . . The actual explanatory mechanisms still need to be determined unequivocally. . . . A final serious problem is the assessment of the significance of the powerful descending influence from the brain on the dorsal horns. . . . It is not even certain that the small cells of the substantia gelatinosa generate nerve impulses (8, pp. 9, 10, 12, 13).

Significantly, they stated that "if the patient is allowed to think about something else or if other strategems to keep the pain under control are employed, slowly rising temporal [pain] patterns are susceptible to central control." More relevantly, they noted that relaxants, tranquilizers, sedatives, suggestion, placebos, and hypnosis exert a profound influence on pain, but unfortunately "the relative neglect of the motivational and cognitive contributions to pain has made these forms of therapy suspect, seemingly fraudulent. . . . These methods deserve more attention than they have received" (8, p. 31).

SUGGESTIVE FACTORS IN ACUPUNCTURAL ANALGESIA

From the welter of mutually contradictory theories and speculations having low predictive value, it is obvious that acupunctural analgesia has not been satisfactorily explained by the Melzack-Wall skin-sensory gating mechanism or by any other theory. I stated that acupunctural anesthesia works largely by "suggestion in slow motion—hypnosis" (17). Others (18) and now Wall (19) are of the same opinion. Wall stated: "My own belief is that . . . acupuncture [anesthesia] is an effective use of hypnosis. This in no way dismisses or diminishes the value of acupuncture, but it does place it in a class of phenomena with which we are partly familiar" (19, p. 130).

I will adduce further evidence for validating these assumptions. Having performed major surgery, much of it solely under hypnoanesthesia, and having studied the official Chinese films and the available reports on acupunctural analgesia, I believe there are several factors operating in a subtle fashion. The profound alterations in perception and cognition accounting for the modus operandi of acupunctural analgesia can be explained in part in terms of contemporary conditioning theory. Another factor is the favorable expectant attitude produced by the ritualistic placement of the needles. The points and meridians on the impressive charts and manikins serve to heighten suggestibility. Still another important factor is the optimism shared by the patient and therapist that the acupunctural analgesia will be successful. Other covert factors are the generalized stoicism, evangelical zeal, and ideological fervor—all built up as the result of a well-established belief system. Such prior indoctrination mobilizes powerful autosuggestive mechanisms. This mental set is somewhat analogous to the Samadhic state of Yoga and the Satori state of Zen. In both, inhibition of painful stimuli can occur. Selected patients for acupunctural anesthesia, especially those who are apprehensive, are trained in Yoga breathing exercises before surgery to induce greater relaxation. Gastaut (20), after studying the EEG patterns of Yoga and Zen disciples, regarded these alterations in awareness as autohypnotic states.

That even the most respectable scientists in the Western or Occidental world are unaware that acupunctural analgesia is largely a type of suggestion and autohypnosis is because either they are not familiar with the basic principles of "waking hypnotism" or they adhere to the commonly held belief that a formal induction technique is always required to produce phenomenological responses. So-called "trance," "sleep states," or "unconsciousness" are not related to hypnosis (21). Barber (22) demonstrated in numerous investigations that all the phenomena attributed to hypnosis, including anesthesia, can be elicited spontaneously without the occurrence of objective signs of hypnosis. Bonica (23), of the National Institutes of Health Ad Hoc Committee on Acupuncture, reported that there are plans to study factors influencing the patient's response to his hypnotizability or previous training and preconditioning. The committee should also investigate the extensive literature on the "immobility reflex" or "animal hypnosis" (14, 24). When animals are restrained, they develop anesthesia due to fear and catalepsy—the so-called "still reaction." Thus the argument that animals are unable to be influenced by Maoism is invalid.

NATURE OF HYPNOSIS

I have described (25) how the hypnotic process is characterized by hyperacuity; increased receptivity and objectivity facilitate one's susceptibility to suggestions, overt or covert. These compound the sensory spiral of belief into conviction—"programmed" faith. Such a linear set of events catalyzed by the experiential background results in supramaximal performance. I also have described hypnosis according to a systems approach and have discussed its neuropsychophysiological relationships to sensory processing of information and control in higher cen-

tral nervous system functioning and behavior (26).

It should be emphasized that hypnosis is a patient-centered response mechanism rather than a therapist-directed modality. Bernheim (27) once stated: "It is indeed a wise therapist who knows who is hypnotizing whom."

Common Denominators in Acupunctural Analgesia and Hypnoanesthesia

The indications and contraindications for acupunctural analgesia and hypnoanesthesia are similar, as is the choice of cases. The advantages of each are identical: both are absolutely safe, the pain threshold is raised, bleeding is lessened, and there is no interference with hydration and pulse and no respiratory difficulties. As in acupunctural analgesia, neurogenic and postoperative shock and complications are markedly diminished during hypnoanesthesia (28).

There are disadvantages to both. Neither can be used in tense or apprehensive persons. Large, strong-muscled individuals are poor candidates. The methods do not always work and often require supplementary conventional anesthesia. However, the success rate of acupunctural analgesia in China is 90 percent—much higher than in the Occidental world. This is surprising; I will discuss some of the reasons.

In the Chinese society, the antecedent cultural variables, the expectations of their leaders, and the beliefs of their doctors bring about strict adherence to Maoism on the part of the population. Thus compliant behavior occurs without the necessity for overt cooperation. In a regimented society such compliance is readily attained, especially if strong sociopolitical reward inducements are present. Acupunctural analgesia is closely related to operant conditioning techniques for shaping and altering behavioral responses. Operant conditioning influences such psychobiologic functions as attention, concentration, and receptivity to autosuggestions. The subsequent alterations in behavior can lead to well-known placebo responses (29).

THE POTENTIATING EFFECT OF ANALGESIC AGENTS

Study of a recent surgical report from China (3) indicates that patients have a choice of conventional anesthesia or acupuncture. Some but not all patients receive some type of analgesic agent, singly or in combination. Morphine, scopolamine, meperidine hydrochloride (Demerol), and sodium pentothal are used preoperatively or during surgery. On occasion novocaine is injected into the peritoneal tissues. Such an array of pain-killing drugs potentiates autogenic training. These and the preconditioning are more than adequate for highly susceptible patients. (This is mentioned only to correct the impression spread by our lay press that acupuncture is the sole agent for pain relief.)

Wei-chi Liu (30) reported the first use of acupunctural analgesia in America, in a tonsillectomy. The patient experienced no pain during the operation, although he reported discomfort in swallowing. However, 2 ml. of fetanyl citrate and droperidal (Innovar) was administered preoperatively. In my series of cases (31) I used no analgesia so as not to contaminate the data and thus invite criticism and disbelief at a time when there was considerable prejudice regarding hypnosis.

PSYCHOPHYSIOLOGIC MECHANISMS IN HYPNOANESTHESIA AND ACUPUNCTURE

Surgeons who use hypnoanesthesia in their operations know that the skin is the principal source of pain. A rapid, deft incision often can be made painlessly on a well-conditioned patient with only moderate analgesia. The muscles, fascia, and peritoneum and the hollow viscera are impervious to pain when incised. As mentioned earlier, only traction produces discomfort in these tissues.

Observing the films made by the People's Republic of China, I noted that some of the patients clutched and read Mao's "Little Red Book" while on the operating table; this is another example of misdirection and autosuggestion. I observed no discernible difference in the behavior of those operated on under acupunctural analgesia and those I operated on who were under hypnoanesthesia except that some of my patients kept their eyelids closed. Unsophisticated observers often will not believe that a patient is hypnotized when his eyelids are open.

Case Illustrations

I would like to describe some cases that illustrate the similarity between hypnoanesthesia and acupuncture for major surgical procedures. In all these cases a large spinal needle was easily passed through the patient's arm, breast, or abdominal tissues—not for misdirection but solely to reinforce the patient's expectation that the "anesthesia" for the desired surgery would be effective.

Case 1. Kroger and DeLee (32) reported the first cesarean-hysterectomy ever performed in the world solely under hypnoanesthesia. The operation was done at the Chicago Lying-In Hospital. The patient experienced no subjective discomfort and conversed with those in attendance. She watched the birth of her baby and saw her removed uterus. Her subjective experiences were identical to those of persons undergoing acupunctural analgesia. She stated: "You get a feeling of detachment. As it becomes complete, your arms and legs feel heavy, then numb, then as if they dropped off. Then you start floating. Your senses do not respond to pain stimuli."

Case 2. On March 3, 1956, at the Edgewater Hospital in Chicago a large tumor was removed from the breast of a 20-year-old patient under hypnoanesthesia. The surgeon, Dr. J. Silverstein, remarked: "I have never seen such remarkable relaxation of the tissues—they were like butter—and a radical mastectomy could undoubtedly have been performed without analgesia or anesthesia" (32).

Case 3. On December 3, 1956, I hypnotized an unselected patient for an extensive breast operation, which was painlessly

performed without anesthesia or analgesia at St. Vincents Hospital, New York City, before a closed telecast at the Tenth Postgraduate Assembly of the New York State Society of Anesthesiologists. The surgeon, Dr. Walter Mitty, noted the marked relaxation of the tissues, the decrease in bleeding, and the absence of pain reflexes and discomfort. He stated: "I easily could have performed more extensive surgery. I would not have believed it if I had not actually done and seen it" (31).

Case 4. On November 29, 1956, Dr. P. Kaplan and I performed a subtotal thyroidectomy under hypnoanesthesia (31). No pre- or postoperative medication was required. The patient talked amiably to the surgical team throughout the surgery, had a glass of water immediately after the operation, jumped off the table, and wanted to walk to her own room. At no time during the 70-minute operation did she have the slightest pain. She stated, "The scalpel felt like a feather being drawn across my neck."

The American Medical Association film catalog lists a motion picture about case 4, "Hypnosis in Thyroidectomy," as well as my film "Hypnosis in Obstetrics." *Childbirth with Hypnosis* (which I co-authored) (33) describes the hypnotic techniques for pain relief and compares natural childbirth and psychoprophylactic relaxation with hypnosis.

THE IMPORTANCE OF AUTOGENIC TRAINING

In all four of the cases I used an adaptation of autogenic training, a method first described by Schultz, a German hypnotist, over 50 years ago (34). I noted that rehearsal of the entire surgical procedure preoperatively blocks the neurophysiological pathways involved in pain transmission. Thus receptors in the higher brain centers, when they are experientially conditioned under autogenic training or autohypnosis, protect the patient from surprise, apprehension, fear, and tension and raise the pain threshold (32). Often, with highly motivated patients, hypnotic induction was not required when autogenic training was employed.

The potent effect of autogenic training was illustrated by the fact that the only time one of my patients complained of pain was when the towel clips were being placed on the abdomen prior to the skin incision. This minor detail had been inadvertently omitted from the rehearsal. That two other patients had similar experiences indicates how well perceptual and cognitive experiences can be organized into a variety of altered responses, depending on the range of the learning processes.

At the Friendship Hospital in Peking, a form of autogenic training is used as a prelude to acupuncture analgesia. Tkach (35) stated that patients are rehearsed several days before surgery; the assigned surgeons describe the entire procedure. In the surgical suite patients are shown how the operation will proceed, what the acupuncturist will do, and what effect the needles will have. Then the patients talk to other patients who have had acupuncture. Finally, at the patient's option, he is given acupuncture needles to experiment with at home.

DISCUSSION

Thus far no one hypothesis, including the two- or four-gate control theories, adequately explains how acupuncture analgesia works. It certainly works in China—for the Chinese. Its success can be explained within the context of contemporary conditioning theories involving the acme of the placebo response—hypnosis. The difference, in my view, is that subliminal but powerful preconditioning and the ritualism associated with the needles have supplanted the verbal and nonverbal suggestions used to induce hypnoanesthesia. Furthermore, the vibratory manipulation of the needles serves to distract the attention span and, as a result of the misdirection of attention, the painful stimuli do not reach the cortex, causing a partial cortical inhibition. Other factors responsible for raising the pain threshold include the emotional contagion resulting from the group interaction established by lengthy autogenic training—a type of autohypnosis—the antecedent cultural variables, the demand characteristics imposed by Maoism, and the regimentation of the Chinese system. All of these serve to modify and change behavioral responses without the necessity for overt cooperation.

Acupuncture analgesia and hypnoanesthesia markedly reduce the need for chemical agents; this is a praiseworthy objective. But acupuncture analgesia is not recognized as a form of hypnosis because many respectable scientists still believe that a formal induction procedure is necessary to induce an anesthesia response. Nor do they realize that the "logic" of the well-conditioned person enables him to accept things that do not make sense. Also, they are unaware that acupuncture analgesia and hypnoanesthesia do not achieve their effects through increased suggestibility per se. Rather, successful patients behave differently when they are "programmed" to think differently. With these dynamisms we can better understand that the psychobiological responses brought about by acupuncture analgesia and hypnoanesthesia are the same; in both, a conviction that pain relief will occur from the respective methods leads to pain relief.

When observers trained in hypnosis and other scientists cross-fertilize their views with Western and traditional Chinese medical workers, their similarities will be better understood. Both acupuncture analgesia and hypnoanesthesia have far-reaching significance for anesthesiology, and each is here to stay. This discussion is not intended as a criticism of acupuncture analgesia. In the environment in which it is being applied, it is obviously the modality of choice and represents a remarkable breakthrough. This presentation is an attempt to clarify its modus operandi, to reconcile the various theoretical formulations, and to demonstrate that it can be explained by a conditioning theory paradigm consisting of autogenic training, Yoga breathing exercises for selected patients, and powerful subliminal suggestions utilized at various levels of awareness. These verbal, nonverbal, intraverbal (intonation of voice), and extraverbal (the implications of words) suggestions increase suggestibility and lead to a form of autohypnosis. Magnetism, the pre-

cursor of hypnotism, has now been replaced by "needleism."

REFERENCES

1. Vieth I (trans): The Yellow Emperor's Classic of Internal Medicine. Los Angeles, University of California Press, 1972
2. Dimond EG: Medical education and care in People's Republic of China. JAMA 218:1552–1557, 1971
3. Dimond EG: Acupuncture anesthesia: Western medicine and Chinese traditional medicine. JAMA 218:1558–1563, 1971
4. Signer E, Galston AW: Education and Science in China. Science 175:15–23, 1972
5. Mann F: Acupuncture: The Ancient Chinese Art of Healing. New York, Random House, 1962
6. Matsumoto T: Acupuncture and US medicine. JAMA 220:1010, 1973
7. Melzack R, Wall PD: Pain mechanisms: a new theory. Science 150:971–979, 1965
8. Melzack R, Wall PD: Psychophysiology of pain. Int Anesthesiol Clin 8:11, 1970
9. Acupuncture explained; or is it? Medical World News, June 16, 1972, pp 11–13
10. Man PL, Chen CH: Acupuncture "anesthesia": a new theory and clinical study. Curr Ther Res 14:390–394, 1972
11. Wall PD: Personal communication, Nov 9, 1972
12. Acupuncture therapy may hit the spot, but is it legal? Medical World News, Aug 4, 1972, pp 15–17
13. Nobel winner explains use of acupuncture as anesthesia. Los Angeles Times, June 9, 1972, p 1
14. Simonov PV, Paikin D: The role of emotional stress in the hypnotization of animals and man, in Psychophysiological Mechanisms of Hypnosis. Edited by Chertok L. New York, Springer-Verlag, 1969, pp 67–87
15. Platonov KI: The Word as a Physiological and Therapeutic Factor. Moscow, Foreign Language Publications, 1959
16. Korotkin II, Suslova MM: Further investigation of dynamic localization of conditioned inhibition produced by suggestion in hypnosis. Zh Vyssh Nerv Deiat 15:53–60, 1965
17. Kroger WS: Hypnotism and acupuncture. JAMA 220:1012–1013, 1972
18. Wykert J: Scientist suggests acupuncture-hypnosis link. Psychiatric News, June 21, 1972, pp 1, 28
19. Wall PD: An eye on the needle. New Scientist 55:129–131, July 1972
20. Gastaut H: Hypnosis and presleep patterns, in Psychophysiological Mechanisms of Hypnosis. Edited by Chertok L. New York, Springer-Verlag, 1969, pp 40–44
21. Kroger WS: Techniques of hypnosis. JAMA 172:675–680, 1960
22. Barber TX: A Scientific Approach to Hypnosis. Princeton, D Van Nostrand Co, 1969
23. Bonica JJ: Acupuncture: fertile ground for faddists and serious NIH research. Science 177:592–594, 1972
24. Volgyesi FA: Hypnosis of Man and Animals. Baltimore. Williams & Wilkins Co, 1966
25. Kroger WS: Clinical and Experimental Hypnosis. Philadelphia, JB Lippincott Co, 1963
26. Kroger WS: Sensory processing and control in higher nervous systems functioning, in Proceedings of the Symposium on Biomedical Engineering. Edited by Sances A. Milwaukee, Marquette University Press, 1966, pp 66–67
27. Bernheim H: Suggestive Therapeutics. New York, Putnam, 1902
28. Kroger WS: Hypnoanesthesia in surgery. Western Journal of Surgery, Obstetrics, and Gynecology 68:25–30, 1960
29. Beecher AK: Measurement of Subjective Responses. New York, Oxford University Press, 1959
30. Liu W-C: Acupuncture anesthesia: a case report. JAMA 221:87–88, 1972
31. Kroger WS: Introduction and supplemental surgical cases, in Hypnosis in Medicine and Surgery. By Esdaile J. New York, Julian Press, 1957, pp 1–37
32. Kroger WS, DeLee ST: Use of hypnoanesthesia for cesarean section and hysterectomy. JAMA 163:442–444, 1957
33. Kroger WS, Steinberg J: Childbirth with Hypnosis. New York, Doubleday & Co, 1961
34. Schultz JH, Luthe W: Autogenic Training. New York, Grune & Stratton, 1959, pp 216–220
35. Tkach W: "I have seen acupuncture work," says Nixon's doctor. Today's Health 50:50–56, July 1972

Crisis, Conversion, and Cult Formation: An Examination of a Common Psychosocial Sequence

BY HERBERT M. ADLER, M.D., AND VAN BUREN O. HAMMETT, M.D.

An overview of prescientific medicine, therapeutic communities, and psychoanalysis is given in an attempt to discover the generic factors operating in all interpersonal therapies. The authors hypothesize that the placebo effect rests on the universal need of humans for a group and, by symbolic extension, a system. Further, they hypothesize that a common therapeutic process follows the sequence of crisis, conversion, and cult formation.

IT IS A PARADOX of medical science that success, not failure, has impeded our progress toward discovering therapeutic specifics. While other disciplines had to await valid theoretical and technological breakthroughs before they could successfully manipulate their fields, medicine, and especially interpersonal psychiatry, was achieving outstanding successes on the presumed basis of theories and practices that we now realize could not possibly have been true. Indeed, it was not until we could recognize and correct for the pervasive placebo effect that we could rationally search for specific therapeutic factors. Just as the *Penicillium* mold was once looked on only as a bacteriostatic contaminant that spoiled culture growths, so the placebo effect has been considered an unwanted therapeutic contaminant that interfered with efforts to isolate specific remedies. It would be ironic if our pursuit of these lesser forces resulted in our ignorance of the mechanisms underlying this enormous power. Because of its universal, timeless, and transcultural nature, it would seem reasonable to expect that an analysis of the placebo effect would yield the generic psychotherapeutic factors in purer form. Since they would be expected to operate in all treatment situations, and most especially in prescientific medicine, let us begin by exploring medical history.

While the bewildering array of therapeutic procedures and the theories that justified them varied both culturally and historically, one can discern two invariable characteristics. First, each etiologic theory explained the condition of illness, possession, deviancy, etc. (the names change with the times) in a cognitively specific way that both expressed and confirmed the prevailing weltanschauung—magic, religious, mystic, rational, etc. The conceptual boundaries of one became the conceptual limitations of the other because medicine was part of the cultural system. At the very least, the sick role provided a socially sanctioned respite while the practitioner fitted the symptoms into a coherent system, syntonic with the culture. Secondly, the practitioners—socially approved healers designated by a variety of names, i.e., shaman, priest, hungan, etc.—occupied a social niche of respect, reverence, and influence comparable to the parental role. It is humbling and informative to recognize that the practices of the most successful and acclaimed physicians of an earlier day are viewed by us with amusement or abhorrence in spite of the fact that in the arena of interpersonal influence their results rival our own.

Thus the historical material suggests that regardless of period or culture, those defined as patients, i.e., distressed or disabled, have always been helped by two aids of incalculable importance—the opportunity to participate in a shared cognitive system that made symptoms understandable and access to a relationship with a culturally sanctioned parental figure. We shall label these "system formation" and "group formation," respectively, and examine them in detail.

GROUP FORMATION

The first mainstay of baseline human functioning is an interpersonal one, which begins as pairing and results in group formation. Its importance rests phylogenetically on the inherent socializing drives adaptively selected for survival in all primates and developmentally on the unrivaled significance of the primordial dyad. As Asch's (1) studies illustrate, the difference between one alone and two together results in a quantum leap in stress resistance and effectiveness. When we take into account that man's capacity for abstraction allows the relationship with the significant other to be real, fancied, symbolic, anticipated, or remembered, we recognize that there are no beings called human who do not have such a relationship.

SYSTEM FORMATION

We use the term "system" to mean a comprehensive, integrated, coherent organization of cognitive structures

The authors are with the Department of Mental Health Sciences, Hahnemann Medical College, 230 North Broad St., Philadelphia, Pa. 19107, where Dr. Adler is Clinical Associate Professor and Dr. Hammett is Professor and Chairman.

The authors gratefully acknowledge the assistance of Ms. June Miller Strickland, Librarian of the Institute of the Pennsylvania Hospital, Philadelphia, Pa.

concerning the total environment, animate and inanimate. In the vernacular, it is an understanding of how things "hang together," and it enables man to locate himself spatially and historically. He can face the present without the insecurity of chaos and the future with some assurance of predictability. Because of the developing human's lack of instinctive knowledge about how to deal with his environment, his survival depends not only on the aforementioned dyadic bonding, but also on a capacity for and drive to acquire the cognitive system of his original group. This learning occurs so early and so consistently that we are aware of no humans without a system; religion, communism, and rationalism are all systems. The normal socialization process moves the individual in his relationship with the group's system from compliance through identification, to internalization, and finally promulgation. The parent who teaches the way through the maze to his child has completed the cycle.

So identified is the system with the group from which it was learned that the emotional security adherent to the original dyad is largely transferred to the incorporated system in the maturing individual, and eventually the system comes to stand coequal with the group as a source of security. It is suggested here that these two factors—group formation and system formation—are the necessary and sufficient components of the placebo effect, are invariably utilized in all successful interpersonal therapies, comprise what is subjectively experienced as a feeling of "meaning," and are as essential to psychic functioning as nourishment is to physical functioning. If this is correct, then we would expect that the drives for group-system formation would be prepotent over arousal drives such as sex and aggression, and that clinically we would find that when the group system relationship is threatened it leads to a crisis in which the arousal drives are either inhibited or intensively pressed into the service of restoring the group system.

Space does not permit an exploration of the entire field of interpersonal therapy, but we will examine two theoretically and procedurally different modalities, the therapeutic community and psychoanalysis. These two have been selected because they represent significant contrasts. The therapeutic community deals with poor prognosis character disorders, using a behaviorally oriented, group approach; whereas psychoanalysis deals with good prognosis psychoneurotics, is insight oriented, and involves a one-to-one relationship. If our hypothesis is correct we should find that the motive for change is crisis (natural or iatrogenic) and that the goal of change is satisfaction of group-system needs.

THE THERAPEUTIC COMMUNITY

The classical tradition of social theory has long recognized that the well-being of the individual is dependent on his full membership in the community. Philip Rieff (2) typified such ideas when he wrote, "To cure a man, one need only return him to his community or construct a new one." If we accept Webster's definition of mental therapeutics as "treatment directed to influencing the mind" and recognize that the issue of "good" and "bad" influence is one decided by the community, it would follow that all communities are, to varying degrees, therapeutic. Of course, the more a community is motivated and structured toward influencing its members, the greater the chance for success—again, in the community's own view. The term "therapeutic community" was originated by Maxwell Jones (3), who conceptualized it as a way of directing and maximizing the therapeutic influence that the mental hospital and its staff bring to bear on the patient.

That such an arrangement need not be limited to hospitals, to residential settings, or even to trained medical personnel was long ago discovered by indigenous self-help groups, such as Alcoholics Anonymous in 1935. As we explore the therapeutic community in its broadest aspect, i.e., the utilization of the social milieu as a major instrument of change (4), we enter a paraprofessional world of treatment that has achieved an unrivaled record of success with a segment of the population unreachable by the standard methods of the medical establishment. Such unpromising groups include drug addicts (Synanon), alcohol addicts (Alcoholics Anonymous), food addicts (Weight Watchers), and prisoners of war (Chinese Thought Reform).

While the programs vary in matters of environmental control, intensity, goals, and duration of influence, they share a commonality of procedures that suggests that they are all tapping into the same basic therapeutic process. To begin with, they require as a condition of entry, or induce in the course of treatment, a state of helplessness in relationship to the "offensive" activity and a disavowal of previous ways of dealing with it: Alcoholics Anonymous calls it "bottoming out," Synanon describes it as "blowing your image," faith cults exhort the convert to "wipe the slate clean," and the Chinese thought reformers aim for "tail cutting." But the common result is an individual in varying degrees of a nonadapted state (5), beset by anxiety and despair, eager for a solution. What follows is a series of personal humiliations, forced confession and self-denunciation, isolation from his previous group, and deprivation of usual comforts, which are only gradually returned as earned luxuries, dependent on his assimilation of the group code and standard of behavior.

The standard may be explicit, as in Alcoholics Anonymous and Synanon, or ambiguous, as in thought reform (6), but in either case its adoption is critical for group approval and sometimes for the individual's physical survival. The group will not tolerate the peripheral member or passive participant, nor is the code modified to meet the individual's objections. Through repetition and increasingly intense relationships with older members and/or the leaders, who are usually ex-deviants "saved" by similar programs, the novice gradually rises through the dominance gradient until he attains the coveted prestige of full group membership. With further training he himself may become a leader, and then his investment in the group and its standards is complete. Not

surprisingly, there is a high attrition rate early in the program, but as participation increases—especially if there is total environmental control—cognitive dissonance, social integration, group cohesiveness, and the satisfaction of being a member of a select elite act as powerful holding forces.

If we put aside the content of these various groups and survey the formal and chronological aspects of this change process, we find a three-step sequence.

1. The patient's original group-system relationships are partially disrupted prior to treatment and further disrupted in the course of treatment. This places him in the unstable, polyvalent condition of crisis.

2. The emotionally prostrate patient is introduced by the leader and/or disciples to a new group system and adopts it as his own (conversion).

3. The newfound emotional security is confirmed by membership in a cult-like organization and maintained by progress through the hierarchical cult ranks.

We may summarize this progression from "disease" through "cure" as involving first crisis, then conversion, and finally cult formation. We believe that just as the group system may be the generic therapeutic agent, the crisis-conversion-cult formation sequence may be a common therapeutic pattern for a significant attitudinal change. While psychoanalysis, with its emphasis on insight and transference resolution, would appear to be an exception, information will be presented that would suggest otherwise.

PSYCHOANALYSIS

Psychoanalysis characterizes itself as a nondirective effort in a neutral setting aimed at increasing the patient's options by increasing his awareness of his underlying psychic processes by means of insight and transference resolution. As a treatment procedure it is based on three interlocking characteristics—the basic rule of free association, insight into unconscious processes through interpretation of defenses and latent content, and the resolution of the transference.

The clinical and theoretical justification for this rationale has been thoroughly amplified elsewhere (7, p. 572) and need not be repeated. Instead, we will attempt to describe the same clinical phenomena from another perspective.

The most obvious and probably the most important factor in psychoanalytic treatment is the intense, long-term doctor-patient relationship. Outside the bonds of matrimony it is as binding a liaison as two consenting adults can agree to within the framework of Western society. While the raison d'être for this alliance is the rational exploration of the patient's unconscious psychic processes, Pande (8) has pointed out that it may also be a rational culture's rationalization for fulfilling man's irrational needs for interpersonal intimacy. Such a therapeutic alliance could be seen as supplying the critical group formation. Within this interpersonal setting, it is the responsibility of the patient to refrain from acting out or "acting in" and to free associate while the analyst listens and interprets. From these interpretations come insights into the patient's unconscious psychic processes, with a resultant change in attitude and perhaps behavior. While this is confirmed by ample clinical evidence, no sufficient explanation is offered as to why presenting a patient with knowledge of his inner drives should of itself lead to these changes. The discovery of alternative modes without influencing activity by the analyst could account for cognitive changes but not for the essential affective and behavioral changes.

Learning theory, on the other hand, does offer a plausible explanation. Studies by Krasner (9), among others (10, 11), have shown that nondirectiveness is an ideal rarely if ever realized in practice. The verbal productions (stories, random free associations, etc.) of a wide variety of subjects were found to respond quite selectively to barely audible verbal and nonverbal cues from the listener. The classes of behavior reinforced in this way ranged from such simple responses as "animals," "plural nouns," and "mother" to more complex and symbolic entities such as affect statements and ideas of self-acceptance. Significantly, the shift of verbal content in the direction of reinforcement occurred *without* the subjects being aware of it. Such studies challenge the likelihood that *any* interpersonal therapies could be nondirective and support Frank's contention that "hypotheses about human nature supported solely by patients' productions in psychotherapy must be regarded as unproven because subtle cues can oblige the willing patient to provide the expected data" (12).

It would thus appear that in the course of psychoanalysis the patient is not simply discovering himself, but in subtle and significant ways he is discovering the analyst's weltanschauung—his system or, to be more precise, subsystem. The insights may be seen as simultaneously establishing interpersonal intimacy, informing the patient of the analyst's system, and discrediting the patient's old system. Since patient and therapist characteristically occupy the same sociocultural niche, it is really the disparity between subsystems that is the focus of their dialogue. As this process continues the patient learns more and more, but for those suffering from deep-seated neuroses such "intellectual insight" does not result in thoroughgoing changes. It is not until the crystallization and resolution of the transference resistance—"the core of psychoanalysis" (7, p. 29)—that treatment is considered fully successful.

Let us examine the events preceding and following the transference resolution to see if other explanations besides the classical one may be invoked. As already described, the patient brings to the analytic situation a historically rooted, time-tested system of interpersonal relationships and cognitions (group system), through the perpetuation of which he attempts primarily to maintain emotional security and, if possible, its ideal physiologic substrate, homeostasis. It may be that the tenacity of the transference reaction and the persistence of the repetition compulsion draw their strength from their rootedness in security-seeking behavior.

We believe that this parallel way of describing transference has the advantage of providing a psychobiological model for understanding normal as well as pathological transferences. When the resurrection of early group-system relationships is accompanied by both emotional security and physiologic homeostasis (as probably occurs in the normal mother-infant dyad), the individual would be in a position of healthy stability. When, however, the security object frustrates and generates physiologic dysfunction, then conflict, psychopathology, and psychosomatic disease may result.

That the patient's subsystem is at variance with the analyst's is inherent in the treatment situation because concurrence of the two is considered the therapeutic end point. Consistently and with increasing intensity the two subsystems confront each other by means of interpretations of the patient's pathological reactions. Even while the patient is being "educated" to the analyst's point of view by means of interpretations and is investing increasing amounts of time, money, and effort in the undertaking, he is unwittingly pressuring the analyst to fulfill his ancient expectations and perceiving the analyst's interactions in such a way that they seem to confirm those expectations.

In any other relationship, the patient's system would be perpetuated by a reactive feedback mechanism from the environment, but this situation is different. Not only are the patient's usual coping mechanisms frustrated by the shadowboxing, but he is confronted by the coherent, rational, and unbending system of an analyst who by now has stepped into the niche of the primordial parent. The patient's system has been discredited by interpretations that additionally both inform him of the analyst's system and support him through empathic communications. The affective and cognitive frustration of the patient's system, combined with his dyadic need to relate, propel him into a nonadapted state vis-à-vis the analyst. This is a landmark in the therapeutic process. The analytic patient, no less than the hypnotic subject, reaches a point where he must either conform or quit. The analyst is immovable. Up to this point, insight has been chiefly "intellectual." From here on, if the patient continues, he will have to discard his crumbling system and seek safety through the substitution of the analyst's system.

Thus the procedure and techniques of psychoanalytic treatment steadily move the patient toward the synchromesh convergence of the two powerful forces for change referred to earlier. We know from many sources that systems are not discarded simply because they lead to frustration. Paradoxically, because frustration increases the need for security, even pathologic systems may be more tenaciously grasped. It is only the combination of the fear of cognitive chaos as the old system dissolves (crisis) coupled with the haven of safety concurrently available through the analyst's system that makes the shift propitious at this time. The process of compliance, identification, and internalization is completed, and the patient has recapitulated with the analyst the original sequence he had earlier experienced with his parents. This is not just self-discovery; it is also conversion. By adapting to the analyst's system and incorporating it within himself, he has added a stable, cohesive, integrating superstructure that will enable him to leave the person of the analyst and still maintain a feeling of safety. The new system tends to perpetuate itself by perceptual-conceptual constancy and identification with the analyst just as the old one had. Whereas brief psychotherapy tends to work by the rapid reestablishment of group formation, psychoanalysis attempts conversion to a new system.

Thus this common sequence of crisis, conversion, and cult formation, utilizing the generic therapeutic needs for a group system, provides a rationale for understanding psychoanalysis as well as therapeutic communities. In this sense, the psychoanalyst is the priest of a rational system or the charismatic leader of a rational cult.

REFERENCES

1. Asch SE: Experimental investigation of group influence, in Symposium on Preventive and Social Psychiatry. Washington, DC, US Government Printing Office, 1957, pp 17–25
2. Rieff P: The Triumph of the Therapeutic. New York, Harper Torchbooks, 1968, p 70
3. Jones M: The Therapeutic Community: A New Treatment Method in Psychiatry. New York, Basic Books, 1953
4. Kraft AM: The therapeutic community, in American Handbook of Psychiatry, vol III. Edited by Arieti S. New York, Basic Books, 1966, pp 542–551
5. Chapman LF, Wolff HG: The cerebral hemispheres and the highest integrative functions of man. Arch Neurol 1:357–363, 1959
6. Frank JD: The dynamics of the psychotherapeutic relationship. Psychiatry 22:17–20, 1959
7. Fenichel O: The Psychoanalytic Theory of Neurosis. New York, WW Norton & Co, 1945
8. Pande SK: The mystique of Western psychotherapy: an Eastern interpretation. J Nerv Ment Dis 146:425–432, 1968
9. Krasner L: Studies of the conditioning of verbal behavior. Psychol Bull 55:148–170, 1958
10. Greenspoon J: The reinforcing effect of two spoken sounds on the frequency of two responses. Am J Psychol 68:409–416, 1955
11. Buss AH, Buss EH: The effect of verbal reinforcement combinations on conceptual learning. J Exp Psychol 52:283–287, 1956
12. Frank JD: Persuasion and Healing. Baltimore, Johns Hopkins Press, 1961, p 228

Telepsychiatry: Psychiatric Consultation by Interactive Television

BY THOMAS F. DWYER, M.D.

The author describes an interactive television (IATV) system set up between Massachusetts General Hospital and a medical station in Boston. The system has proven to be feasible and acceptable to individuals and institutions in the community, providing psychiatric skills on a much wider scale, in a more accessible way, and faster than any other system. The author delineates the implications and future uses that appropriately placed IATV links could have, such as significantly multiplying existing manpower and more evenly distributing psychiatric care without placing greater demands on manpower.

THERE IS INCREASING AGREEMENT that improvement of medical care will not be made merely by adding professionals and that it will require a restructuring of the patterns of health care (1, 2). The incorporation into medical practice of relevant technological innovations is an essential part of such reorganization. Telephone calls between physician and patient are so ordinary that they are hardly thought of as technological advances in communication that frequently substitute for office visits. Interactive television (IATV), which links geographically separated locations by two-way audiovisual signals that are transmitted by cable or microwaves, deserves attention for its potential contribution to improving medical care delivery and specifically, psychiatric care (3–5). Since the cable television systems that are now emerging in many cities across the nation can carry interactive medical care *if* channels are reserved for this purpose, defining the role of IATV in medicine has become an urgent matter (3, 6). The following paper describes a slowly evolving two-and-one-half years' psychiatric use of an IATV system by my colleagues and me.

THE SETTING

The microwave bidirectional television linking the Massachusetts General Hospital (MGH) in Boston with its Logan International Airport Medical Station (about 2.7 air-miles away) began operation in April 1968. The medical station, administratively a unit of MGH, is manned 16 hours each day by nurse-clinicians who have had special training in diagnosis and therapy and by physicians who are present for a few scheduled hours each day. In one of the examining rooms of the medical station there is a remote-controlled camera, as there is in a room at MGH. The controls at the MGH end permit the operator to move both cameras to follow someone around either room, to zoom in and out, and to alter the focus. There is, in addition, a hand-operated camera at the medical station to permit close-ups or simply a different view; a switch at the MGH end determines which camera will be used.

There is also a 17-inch monitor at each end that shows the scene at the opposite terminus. The camera is located directly below each monitor so that the person talking to the individual on the monitor is picked up by the camera in such a way that it appears as though he is looking at the person at the other end (the slight deviation from eye to eye contact is rarely noticed by patients or professionals). The cameras require only ordinary lighting, and in general there is nothing about the rooms that is suggestive of a studio. The system permits, in addition to an audiovisual exchange between patient and doctor, the microwave transmission of such data as ECGs, blood pressure, and blood smears magnified 1,000 times. The system, called Telediagnosis (TDX),[1] has permitted the delivery of health care to more than 1,600 patients up to mid-1971.

A similar but separate microwave system linking MGH with the Bedford Veterans Administration Hospital, a psychiatric hospital about 20 air-miles away, has been in operation since March 1970. Although some of the experience we have gained has been with this second system, this paper will deal almost exclusively with the system running between MGH and the medical station at the airport.

PSYCHIATRIC SERVICE FOR INDIVIDUAL PATIENTS

Shortly after TDX linked MGH with the medical station in April 1968, patients in need of psychiatric help were interviewed and treated or referred. In the absence of systematic psychiatric coverage most of the patients

Dr. Dwyer is Psychiatrist, Massachusetts General Hospital, Fruit St., Boston, Mass. 02114, and is also Assistant Professor of Psychiatry, Harvard Medical School, Boston, Mass.

This work was supported by Community Health Services Project CH 23-41A6 and 19487 from the Health Services and Mental Health Administration and by Award Certificate EMI-69-001 from the Veterans Administration.

[1] This system was planned and directed by Kenneth T. Bird, M.D., Associate Physician, Medical Service, Massachusetts General Hospital, Boston, Mass. Dr. Bird is also the director of the interactive television system, called Teleconsultation (TCX), that links the Bedford Veterans Administration Hospital and MGH.

who were seen over TDX in the first year represented emergency problems. Beginning in April 1969, in preparation for the opening of the second closed-circuit link to Bedford, I invited the medical station professionals to schedule for me all patients with psychiatric problems. Later I arranged for other psychiatrists, for psychiatric residents, and for medical students to contribute additional time for psychiatric consultations. During the subsequent two and a half years, I saw about 30 patients and my colleagues saw an additional 120, each patient being seen between two and 20 times. Initially, all of the patients were employees at the airport or were family members of employees. More recently, as will be described later, we have begun to see patients from outside the airport population. A rough breakdown of the referral sources of these patients follows: self-referred—20; court—30; medical station—20; schools—30; community physicians—10; employers—15; and miscellaneous East Boston and neighboring social agencies—25.

Patients are brought into the medical station TDX consultation room by the receptionist and introduced to the physician on the monitor; the receptionist then departs, leaving the patient "alone." In order to protect against invasion of privacy, we have a firm rule that no one is allowed to observe a transaction without first obtaining the permission of the patient and the professional. Any observer is ordinarily also introduced visually. Written permission is not sought except in the less usual instance where videotape recording is planned.

With very few exceptions the patients were being seen by a psychiatrist for the first time. The accessibility of the psychiatric help may have led patients to seek out and accept help earlier than they would have ordinarily done.

The following case history is an example of an IATV transaction.

Case 1. A male trucker, age 43, came to the medical station with minor hand injuries incurred while unloading a truck. He appeared to the nurse as depressed and tense, and he was offered and accepted a psychiatric evaluation via IATV. In the interview with me, he talked of his wife, from whom he had been separated for some years, and of their children. Projection of his anger to others was prominent, and it was evident that he was a significantly depressed man who might have paranoid ideas.

During an interview a few days later, there was increased evidence of paranoid thinking and greater tension. He complained about being "hemmed in" and asked if I remembered the sniper in a Texas tower; he had thoughts of climbing to the roof of his trucking company and "shooting it out" with the police.

The mixture of depression and anger that I saw left me uncertain of what this man might do. My unfamiliarity with the system (this was the first patient I had interviewed over television) made me additionally uneasy and led to my giving him an appointment for the next day instead of referring him for clinic treatment as I had originally planned.

Early in the third TDX interview I confirmed my previous impressions that the man was a manipulator, and I became more confident that he was trying to make me feel overly anxious. With this greater sense of knowing what was going on, I was able to discuss referral to a psychiatric clinic and to elicit, during the discussion, his negative feelings about psychiatrists. Talking these feelings out, he accepted referral.

This patient represented an extreme test for a psychiatrist who was new to IATV. Being forced to decide whether the patient was homicidal during the second IATV interview created considerable anxiety and uncertainty, although not so much that I gave the patient a separate appointment to see me in my office. By the third interview, greater familiarity with the system and an increasing conviction that the patient was following familiar patterns of behavior enabled me to act as I would if the patient were in my office.

This case was the single most dramatic one seen in the two and a half years. Although a small proportion of patients (approximately five percent) of all those seen on IATV had severe psychiatric disorders, the vast majority interviewed had acute situational crises and could be helped in one or two interviews. Services provided to individual patients have ranged from diagnostic interviews for adults and for children as young as age 12 (47 percent); treatment using interview techniques alone or a mixture of interviewing and prescribed drug therapy (20 percent); brief intervention in acute crises (33 percent); and prolonged supportive and explorative therapy for some patients with a character disorder or with a frank psychosis (seven percent).[2] Group therapy has been especially effective, although requiring modification of the audiovisual equipment for higher fidelity. We have collected a number of interesting and puzzling responses to IATV use from both professionals and patients especially in the group situation; these will be the subject of a forthcoming publication.

PSYCHIATRIC SERVICE TO INSTITUTIONS IN THE COMMUNITY

While continuing to provide psychiatric services to individuals, we have, since August 1970, sought out a wider variety of psychiatric uses and users. Our aim in these divergent projects has been to discover what psychiatric activities can or cannot be conducted with the existing system. A longer-range goal is to determine the feasibility of this or modified systems as vehicles for delivering various types of mental health care.

Geographic factors have influenced who uses IATV in the same way that they originally influenced the location of the IATV system connecting MGH and Logan International Airport. Some users, for example, have difficulty getting to the hospital. Although the airport, which is in East Boston, is only 2.7 air-miles away from MGH, in order to get there one must use a tunnel and a bridge, both of which are subject to traffic tie-ups. In rush hour the normal five- to ten-minute trip may take 30 to 60 minutes or longer. Individuals from cities and towns

[2] This total exceeds 100 percent because of some overlapping in the categories.

located northeast of Boston have similar problems traveling into Boston, although they have ready access to the airport.

Following are some examples that briefly illustrate the range of uses to which IATV is now being put.

Junior High Schools

Since September 1970, the principal and teachers from the junior high school in a town about ten miles away from the airport have traveled via TDX to a weekly meeting with a psychiatrist; the school counselor has a separate weekly meeting with the psychiatrist. Via TDX problems with individual students and general issues are discussed, and students are referred for evaluation or counseling when these are needed.

Several months after these consultations had begun, the schoolchildren were invited to use the system to talk from the medical station with a professional at MGH in small, self-selected groups (four to six members). Each group met a total of three times during school hours. Out of approximately 160 students, 60 indicated an interest and returned with signed permission from their parents. After the groups had begun to operate, positive feedback resulted in approximately 20 additional students' joining the existing groups, so that finally about half of the children in the school were seen. The details of this program will be described in a separate publication.

Other junior high schools, two from East Boston and one from adjacent Chelsea, are also sending children with problems to the system for evaluation.

Municipal Court

Beginning in September 1970, regular weekly meetings between a psychiatrist and the probation officers of the municipal court in East Boston were established. During these meetings, problems that the probation officer has encountered with the juveniles in his care are explored with the psychiatric consultant and, where appropriate, the youngster and his parent are referred for individual evaluation by an appropriate professional. The majority of these juveniles are referred for evaluation of their drug use and treatment needs.

Deer Island House of Correction

Starting in May 1971, prisoners at the Deer Island House of Correction who are required to have a psychiatric evaluation have been taken to the medical station and interviewed via IATV by a professional at MGH. This use of IATV has resulted in rendering more prompt service to the Deer Island prisoners and in cutting the evaluation time to approximately one hour. All of this hour is currently spent with the prisoner, as compared with a minimum of three hours previously spent for the entire trip.

Voluntary Youth Agencies

Voluntary institutions organized to take care of juveniles have been bringing their clients to the medical station for evaluation of the youths' psychiatric problems. These youngsters are frequently runaways or "throwaways."

Staff Meetings

The nurse-coordinator of telepsychiatry and other personnel at the medical station met regularly via IATV with psychiatrists and others involved in the project at MGH. This allows for a periodic review of events and information exchange and is used to provide further insight into the use of IATV.

Extensions of Telediagnosis Currently Under Review

The demonstrated usefulness of the TDX system for consultation and care has stimulated proposals for extending it. The development of Teleconsultation, connecting MGH with Bedford VA Hospital, was in part an outgrowth of the demonstrated effectiveness of IATV. (The operation of this system will be described in a separate publication.) Plans are now being considered to connect MGH with the nearby Bunker Hill Health Center in Charlestown.

The existing IATV link between MGH and its medical station is being used as a "pilot plant" in our work with individuals who are outside the airport population. If uses by a variety of individuals and institutions seem feasible and if the projected volume of use warrants it, the IATV system will be extended. For example, we envision establishing a satellite facility comparable to the medical station in the East Boston community. It will serve as a health center for all ages and will be linked to the medical station by microwave. Meanwhile, appropriate uses of the current system can demonstrate the usefulness and economic value of such an extension without purchasing equipment and space that would be necessary for the actual establishment of a satellite clinic.

DISCUSSION

I approached the use of television to interview psychiatric patients with considerable negative prejudice, believing that the degree of personal contact with the patient would be limited and that many of the skills that are useful in a psychiatric interview would be diminished or lost. I was delightfully surprised to discover that this was not true. Other psychiatrists were also originally skeptical of the feasibility of interviews by this medium, but those who subsequently used TDX became positive about its potential for one-to-one and group therapy. The initially negative responses of some professionals carrying out group therapy and especially psychodrama is a matter of some interest that we are currently studying. At the time this paper was written about 30 psychiatrists and an equal number of psychiatric residents and medical students had used the television system, and all have responded to their experiences positively.

Along with whatever other factors contribute to the initially strong negative reactions, it seems that if the previous experience of psychiatrists has been limited to watching unidirectional television programs that provide

no opportunity for interaction they have a totally inappropriate model for visualizing psychiatric transactions over an interactive television system. The preponderant current uses of television in medicine (if the literature is representative) include live, one-way transmissions and making videotape recordings for purposes ranging from education to therapy. These applications are enormously useful (7). However, previous experience with videotapes or with one-way closed-circuit television does not instruct one in the potential uses of (two-way) IATV. Viewing a videotape recording or a live transaction is identical to watching broadcast television. One views the material being presented in either situation with varying degrees of attention and may react to it with his own thoughts or, if someone else is present, with that other person. However, *there is no interaction between the viewer and the person on the monitor.* The interaction that inevitably takes place in bidirectional television makes this experience qualitatively different from other experiences with television.[3]

It seems advisable to pay attention to these issues because the introduction of new methods that can facilitate medical care frequently stumbles over problems of acceptance. The stethoscope, for example, was ridiculed when it was first proposed as an aid to chest examination. We have collected observations of a number of professionals who, apparently out of anxiety in their initial encounter with the system, complained loudly that they could not clearly see or hear the person at the other end, while at the same time neglecting to use the simple controls that would have enabled them to bring the patient into focus or to turn the volume up. It is likely that the use of IATV and its adoption by psychiatrists and patients will proceed quickly if the organizers cope with the irrational responses of some users.

The fact that one can have psychiatric transactions over IATV with all of the usual developments, including transference and countertransference reactions, is important and calls for reexamination of some of our fundamental concepts about the nature of a relationship between two people, how it is established and maintained, and what interferes with it. The fact that two or more people can be "in touch" with each other even though the contact is mediated by electronics invites a questioning of many beliefs that we take for granted. It is too early to say that *nothing* is subtracted from the television interaction as compared with interaction in the same room, but it is certainly clear on the basis of experience thus far that a high degree of personal contact can be made between two or more individuals using IATV. It remains to be seen whether there are kinds of patients or professionals who find a crucial ingredient missing in IATV contact. If, with more experience, it is discovered that essential elements of human contact are missing for some individuals, the possibility will still remain of discovering substitute measures to achieve what is wanted. A simple example is the handshake: It is quite possible that it can be replaced by additional verbal or by other nonverbal expressions.

Experience does suggest that for some patients communication with a psychiatrist by means of IATV is *easier* than contact in the same room. This appears to be true of certain patients with schizophrenia and with adolescents and younger children. On the other hand, a rare patient has shown slight anxiety for the first few moments, but has then proceeded quite normally in the interview. A number of patients with delusions have been interviewed over IATV, and to date none has incorporated the television system into his distorted thinking. Most of the issues raised here and other related ones await systematic study.

IMPLICATIONS

An extended IATV system offers the possibility of an enormous leap forward in carrying psychiatric help to the population. A rationally planned psychiatric care system would include the provision of three kinds of facilities interconnected by IATV. In the community a medical station manned by nurses and other professionals who have been specially trained to diagnose and to treat psychiatric problems would provide immediate psychiatric help; and the treatment of many patients might end there. If the diagnosis or treatment were in doubt, the patient would be seen via IATV by a professional from the community or urban hospital and treated or referred. Patients who currently need to go through complicated and irrational webs in order to find appropriate psychiatric help (and many fall out of the system during the arduous attempt) would be treated near their homes. The proposed network has potential for the early detection and treatment of problems and more efficient use of helping persons and thus offers a method for a more cost-effective application of mental health principles. The costs of such care will be substantially lower if, as envisaged, telepsychiatry is a subsystem in a larger telemedicine system that uses time sharing to attain maximum effectiveness.

A further consideration is the rational use of space. The medical station has a sizable waiting room that has absorbed, without any dislocation of its usual activities, the additional traffic generated by telepsychiatry. Space in a central hospital such as MGH is always costly and at a premium. One of the major accomplishments of IATV for medical use is the sharp reduction in transporting people, whether patients or professionals. Only those persons requiring hospitalization for a psychiatric disorder would be transported to the community or university hospitals. Large numbers would be screened out of currently congested centers by receiving early and appropriate treatment at the satellite facility.

The system is not envisaged as a one-purpose medical facility. Current and impending changes in medical prac-

[3] Individuals who visit the system are introduced to participants at both sites and are advised that they are expected to participate in the discussion. I am indebted to Professor Freed Bales of Harvard University for pointing out that asking the observer to participate changes his set away from being a passive witness and toward being an active participant who is expected to respond to the transaction. This has been a most helpful observation.

tice in this country require that a good deal of the wisdom that practitioners in the community have be shared with colleagues in medical centers and that practitioners have easier access to new knowledge. The IATV system can serve as a highly suitable medium for exchanging information in a two-way operation (8).

There are new legal requirements with regard to medical care that will enhance the usefulness of IATV links. In Massachusetts a law currently being implemented requires an increased minimum number of mental and physical examinations for patients at state hospitals in any given period of time. It seems unlikely that these requirements can be met by the current staffs of the hospitals; alternatives include the addition of (unavailable) psychiatrists or putting the ones available to better use by means of IATV.

The recently revised standards set forth by the Joint Commission on Accreditation of Hospitals, which for the first time require each hospital to have a written plan for the care or referral of individuals needing mental health services, will also enhance the usefulness of IATV links. A community hospital that is unable to supply, from within its own walls, all of the psychiatric assistance necessary to maintain its accreditation could have the appropriate psychiatric services were it connected to a functioning IATV psychiatric link.

Increasing use of IATV for direct psychiatric care and consultation calls for measures that will ensure the privacy of the patient and the professional. Existing principles are adequate, but they need to be spelled out and thought through in their application to exchanges that take place with IATV. Personnel, unless otherwise oriented, may become casual about wandering in and out of the rooms where interviews are being conducted. Since this can be done without any disturbance to the patient—indeed, without the patient's knowing it—it is more crucial than usual that the professional take complete responsibility for the protection of those involved (9).

REFERENCES

1. Farfield SR: Delivery of medical care. Sci Am 222:15–23, 1970
2. Code CF: Determinants of medical care—a plan for the future. N Engl J Med 283:679–685, 1970
3. Singer AL Jr: Issues for Study in Cable Communications. An Occasional Paper from the Alfred P Sloan Foundation. New York, Alfred P Sloan Foundation, Sept 1970, pp 3–19
4. Del Vecchio R, Dundas E: Telecommunications for mental health: prospects for the seventies and eighties, in Videotape Techniques in Psychiatric Training and Treatment. Edited by Berger MM. New York, Brunner/Mazel, 1970, pp 251–257
5. Solow C, Weiss R, Bergen B, et al: 24-hour psychiatric consultation via TV. Am J Psychiatry 127:1684–1687, 1971
6. Unger C: CATV in Boston: the prize that has had Howard Hughes, Lyndon Johnson, and Warner Brothers drooling. Boston After Dark, Feb 29, 1972, pp 22–25
7. Shafer M: An integrated system for instructional television, including self-study and laboratory communications. Ala J Med Sci 7:168–171, 1970
8. Trotter B: Television and technology in university teaching. A report to the Committee on University Affairs and the Committee of Presidents of Universities of Ontario. Toronto, Ont, Canada, Dec 1970 (processed), pp 1–59. Available upon request from Information Branch, Department of University Affairs, 481 University Ave., Toronto, Ont., Canada.
9. Rosenbaum M: The issues of privacy and privileged communication, in Videotape Techniques in Psychiatric Training and Treatment. Edited by Berger MM. New York, Brunner/Mazel, 1970, pp 198–206

Factors Affecting Referral to Determine Competency to Stand Trial

BY GERALD COOKE, PH.D., NORMAN JOHNSTON, M.A., AND ERIC POGANY

Prior research has suggested that the competency referral has often been utilized for purposes other than evaluation of the defendant's mental competency to stand trial. This study, which analyzed referral rates in terms of differential arrest rates by crime and by geographical areas, provides more substantial findings on the factors affecting competency referrals. Proximity to evaluation facilities and knowledge concerning the use of competency evaluation laws were among the identified factors.

A LARGE MAJORITY OF STATES now have laws concerning competency to stand trial which stipulate that an individual's psychological functioning must meet certain criteria (1) before he can be proceeded against in a court of law. Although these laws vary somewhat, the Michigan law (Michigan Statutes Annotated 28.966 [11]) is representative:

> A person accused of a crime who is incompetent to stand trial shall not be proceeded against while he is incompetent. A person is incompetent to stand trial within the meaning of this section if he is incapable of understanding the nature and object of the proceedings against him, of comprehending his own condition in reference to the proceedings, or of assisting in his defense in a rational and reasonable manner.

In Michigan the issue of competency may be raised by the judge, prosecutor, defense attorney, or any interested party, on leave of the court. Once the issue is raised, all competency evaluations in the state are, by law, conducted by the Center for Forensic Psychiatry (CFP). The CFP has 60 days from the date of the court order to make and submit its evaluation to the court. The court then considers the recommendation of the CFP, and if the defendant is adjudicated competent he proceeds to trial. If he is adjudicated incompetent he is committed to the Department of Mental Health for a period not to exceed 18 months. During the course of treatment he may be certified back to the court as competent. If he does not regain competency within 18 months a civil commitment order may be issued.

The authors are all with the Center for Forensic Psychiatry, Box 2060, Ann Arbor, Mich. 48106, where Dr. Cooke is Psychological Consultant, Mr. Johnston is Research Psychologist, and Mr. Pogany is Forensic Coordinator. Dr. Cooke is also Assistant Professor of Psychology at Wayne State University, Detroit, Mich., and Mr. Johnston is also Associate Director of Administrative Services at Yorkwood Center and Lecturer of Psychology in Nursing at the University of Michigan.

The authors wish to thank Newton L.P. Jackson, Ph.D., Psychology Director, Center for Forensic Psychiatry, for his critical reading of the manuscript.

STRATEGIES FOR RAISING THE COMPETENCY ISSUE

It is known that doubt concerning the defendant's mental status is not the only reason for making a competency referral. A number of investigators (2–4) have discussed the varying strategies that may be behind the competency referral. These authors emphasized that invoking the competency procedure, besides being a delaying mechanism, is a sure way of obtaining psychiatric examination; they discussed a number of reasons why either the defense or the prosecution might want such an examination. In general, such evaluation leads to a consideration of whether some alternative to trial on the charges is available. The desire to find an alternative may be based on a number of factors. Matthews (4) suggested that a competency procedure is frequently initiated if the type of crime is especially "serious, violent or atrocious." In these circumstances a determination of incompetency removes public pressure for severe punishment from the prosecutor. Also, for both the prosecutor and defense attorney a trial by jury on the responsibility issue is avoided. Conversely, competency referral can also be seen, from the defense's point of view, as groundwork for a "not guilty by reason of insanity" (NGRI) plea in serious crimes likely to result in long sentences.

Eizenstat (2), in discussing abuses of the competency rule, indicated that in some states (e.g., Massachusetts) it acts as a short circuit for the more involved civil commitment procedures. He stated that, especially for defendants with a history of mental illness, incarceration based on incompetency provides a much less difficult means of disposition. It may also provide an even more final form of disposition since the incompetent defendant is unable to take advantage of the discharge and temporary relief procedures available to the civilly committed. If the patient is found competent, disposition recommendations derived from the evaluation may provide the basis for the defense to suggest an alternative to imprisonment for the guilty defendant.

Hess and Thomas (3) suggested that in Michigan, the competency issue is most frequently raised to deal with situations for which there seems no other recourse under the law, rather than on the basis of the accused's mental condition. These authors stated that the criminal charge in many localities is a jurisdictional ploy to raise the competency issue for "undesirables for whom no other criminal disposition appears appropriate."

IMPLICATIONS OF REFERRAL STRATEGIES

These various strategies have a number of implications for the type and characteristics of patients referred for competency evaluation. The most basic implication concerns the types of crimes for which persons are referred. The implication of the strategy discussed by Matthews is that the rate of referral will be proportionately greater for serious crimes of violence (e.g., murder, assault, robbery) or crimes likely to offend public morality (e.g., rape and other sex crimes). On the other hand, the strategies discussed by Eizenstat and by Hess and Thomas suggest that charges which can be easily brought (e.g., drunk and disorderly) will occur with a greater than expected frequency.

A second implication concerns the distribution of referrals over geographical areas, in particular, urban-rural areas. If, as Hess and Thomas suggested, competency referral often involves a jurisdictional ploy, it might be expected that rates of referral would vary widely over geographical areas. The distance from evaluation facilities and the differential knowledge of the presence and function of the facilities by urban as opposed to rural judges and attorneys are two possible sources of geographical variation in referral rates.

A third implication concerns the level of psychopathology of the persons referred. It might be expected that many of those referred suffer from psychotic disorders that legitimately raise the question of competency. However, the tendency to invoke the competency referral as a strategy implies that many of those referred will not be suffering from such a deep level of pathology. Specifically, since a large number of those accused of committing "serious, violent or atrocious" crimes are referred as part of a strategy, many of them may be expected to be nonpsychotic, in spite of the seriousness of their crimes. (If seriousness of crime is related to level of pathology, the degree to which strategies are used in serious crimes may be obscured; however, the data from our own research will be analyzed to see if such a relationship exists.)

PRIOR RESEARCH ON THE CHARACTERISTICS OF "COMPETENCY" PATIENTS

Several investigators have studied the type of crime and the level of psychopathology of persons referred for competency evaluation. A number of studies (5–9) reported the frequency of referral by crime.

Balcanoff and McGarry's analysis (5) of their Massachusetts data indicated that most referrals fall into the burglary-larceny-theft category, with homicide and robbery sharing the position of second highest and assaults being next. The fewest referrals were for sex crimes. Drummond's findings (6) in Florida were similar in that the most frequent charges were "serious property crimes such as burglary, larceny, robbery."

In contrast, two studies by the Temple University group (7, 8) showed consistency over a three-year period in the frequency of referrals by crime in Pennsylvania, but their ranking was quite dissimilar from that of Balcanoff and McGarry and of Drummond. In the Temple studies most referrals were for assaults, with burglary second and sex crimes third; the fewest referrals were for homicide. Sex crimes were third in the Temple studies but lowest in Balcanoff and McGarry's study; homicide was the lowest in the Temple studies but second highest in Balcanoff and McGarry's study.

Finally, a study by Maxon and Neuringer (9) of competency evaluation in Kansas using a gross division of crime type found that most referrals were for nonserious crimes, followed by serious violent crimes, with serious property crimes last.

The inconsistency of the findings concerning crimes of patients referred for competency evaluation is overwhelming. While there is likely to be some variability in the tendency of judges and attorneys to utilize the competency referral for different crimes, there is a confounding variable that may to a large degree be responsible for the inconsistent findings. This variable is the difference among states in how often certain crimes occur. In part, this difference may be a function of both the different physical living conditions in Massachusetts, Pennsylvania, Florida, and Kansas and the different social and urban-rural living conditions that exist in those states. Thus the data on frequency of referral are inadequate; a meaningful analysis must involve the rate of referral for competency evaluation for various crimes as a function of the rate for each crime within the state.

A number of studies of the level of psychopathology of persons referred for competency evaluation are also available (6–12). These studies generally indicate that most patients referred for competency evaluation are *not* psychotic, thus supporting the contention that the defendant's mental status is often not the reason for the referral. The studies cited vary as to the percentage of patients classified as psychotic from ten to 47 percent. Most of the patients fall into the character disorder category, with most studies reporting only a few patients classified other than as psychotic or with a character disorder.

We were unable to discover any prior research that would indicate the distribution of referrals relative to frequency of crime within geographical areas of a state. Of particular interest in the study reported here are two comparisons: first, a general urban-rural comparison and second, a comparison of the major metropolitan area, Detroit, with the rest of the state of Michigan. Because metropolitan areas attract more knowledgeable attorneys, it is expected that referrals will be proportionately higher in Detroit and other urban areas for most crime categories. A possible exception is that particularly serious or "atrocious" crimes, which are less common in rural areas, may be more likely to be considered by judges and attorneys in those areas to be associated with mental illness; this would lead to more frequent referral in such cases.

To summarize, previous theoretical and research articles have indicated that the competency referral is often utilized for purposes other than the evaluation of the de-

TABLE 1
Arrest and Referral Rates by Category of Crimes for Which Competency Referrals Were Made in Michigan, 1969*

Crime**	Arrests	Percentage of Total Arrests	Referrals	Percentage of Total Referrals	Referrals per 1,000 Arrests
Homicide	559	1.0	66	21.6	118
Arson	277	0.5	9	2.9	32
Sex crimes	1,891	3.4	35	11.5	19
Robbery	2,463	4.4	34	11.1	14
Forgery-counterfeiting	1,959	3.5	14	4.6	7
Assaults	11,160	20.0	64	21.0	6
Stolen property	1,982	3.6	13	4.3	7
Weapons	4,986	8.9	11	3.6	2
Narcotics	5,035	9.0	11	3.6	2
Embezzlement	385	0.7	1	0.3	3
Burglary-larceny-theft	25,048	44.9	47	15.4	2
Totals	55,745		305		5

*Not all who are arrested are charged. Since the competency issue cannot be raised until the person is charged, a tally of those charged would be preferable, but these data are not available unconfounded by other factors.

**No other category had more than one referral nor a rate of referrals per 1,000 arrests of more than .2. There were 21 persons referred for other crimes; they are excluded from further analysis.

fendant's mental competency to stand trial. Hypotheses concerning the basis for such referrals have led us to investigate the type of crime, the level of psychopathology, and the geographical source of referral, as well as the interactions of these factors, in an attempt to empirically determine what factors affect the competency referral.

METHOD

The records of all persons seen for competency evaluation at the CFP in 1969 (N = 326) were evaluated in terms of primary criminal charge, diagnosis, and county of referral. Data on the number of persons arrested by crime and the rate of each crime by county in the State of Michigan during 1969 were obtained from the Michigan State Police Department.

RESULTS

The frequency (and percent of the total) of arrests by crime, referral by crime, and referral rate per thousand arrests are presented in table 1. In terms of raw frequencies, most referrals were for homicide, followed closely by assaults and by the burglary-larceny-theft category. Sex crimes were fourth and robberies fifth. The meaninglessness of raw frequencies is demonstrated by the referral per thousand arrest ratio. Homicide remained the most frequent charge for which referrals were made, but the extent to which homicide is overrepresented in the competency referral population is apparent only from the ratio, which is nearly four times the next closest ratio. Arson, for which there were few referrals in terms of absolute frequency, moves into the second position, sex crimes are third, and robbery fourth.

Referrals for assault and particularly for burglary-larceny-theft crimes were infrequent in terms of the number of arrests for these crimes; this provides an obvious indication of the misleading information obtained when the frequency of the crime is not taken into account. The crimes for which referral was least likely to occur were burglary-larceny-theft, followed by narcotics and weapons violations. A chi-square analysis using the arrest rate for each crime as the expected frequency and referral rate as the observed frequency is significant ($p<.001$), statistically substantiating the finding that rates of referral differ systematically as a function of crime.

In table 2 the information presented in table 1 has been further broken down by geographical area. Chi-square analysis for each crime using the total referral per thousand arrest rate as the expected frequency for each geographic area reveals significant ($p<.05$) values for the following offenses: arson, forgery-counterfeiting, stolen property, and embezzlement. Referrals for arson were relatively high in the Detroit area and low in the outstate area (all areas outside the tri-county Detroit statistical metropolitan area) in general and the outstate urban area in particular. Referrals for forgery were high in the outstate rural areas and low in the outstate urban areas. Referrals for stolen property were high for Detroit and low outstate. Referrals for embezzlement came only from the outstate urban areas. The distribution of referrals by crime is not significantly related to geographical source for any other crime category. However, the overall rate of referral is significantly higher for Detroit, and there is a trend for the rate to be higher in all urban than rural areas.

The rate of referral per arrests is not necessary for studying the relationship of crime to diagnosis; therefore raw frequencies are presented in table 3. Chi-square analysis of diagnosis within crime was calculated, using for

TABLE 2
Arrest and Referral Rates by Crime and Geographical Area

Crime	Detroit			Outstate Urban*			Rural		
	Referrals	Arrests	Referrals per 1,000 Arrests	Referrals	Arrests	Referrals per 1,000 Arrests	Referrals	Arrests	Referrals per 1,000 Arrests
Homicide	45	387	116	12	105	114	9	67	134
Arson**	6	97	62	1	102	9	2	78	26
Sex crimes	17	804	21	10	711	14	8	376	21
Robbery	20	1,673	12	11	614	17	3	176	17
Forgery-counterfeiting**	7	843	8	1	607	2	6	509	12
Assaults	41	5,452	8	17	3,339	5	6	2,369	3
Stolen property**	11	1,169	9	1	458	2	1	355	3
Weapons	10	2,926	3	0	1,439	0	1	621	2
Narcotics	9	2,822	3	1	1,436	1	1	777	1
Embezzlement**	0	173	0	1	107	9	0	105	0
Burglary-larceny-theft**	28	12,392	2	15	7,680	2	4	4,976	1
Totals	194	28,738	6.75	70	16,598	4.22	41	10,409	3.94

*A county is defined as urban if it meets the Standard Metropolitan Statistical Area (SMSA) criteria of having at least one core city of 50,000 and meets the metropolitan characteristics set forth by Peterson (13).

**Chi square significant at $p < .05$.

expected frequency a percentage of the total for that crime which would be expected if the distribution followed the total distribution independent of crime; that is, it was expected that 47.2 percent would be diagnosed psychotic, 39.4 percent personality disorder, and 13.4 percent other. The diagnostic category was significantly ($p<.05$) related to crime only for robbery, where there were fewer psychotic persons and more with personality disorders than would be expected using the total distribution.

The frequency of diagnosis by geographical source of referral is presented in table 4. Chi-square expected frequencies were determined using margin totals. The chi-square analysis indicated that the geographic source of referral is not systematically related to diagnosis.

DISCUSSION

It is clear from the results of this study that raw referral rates cannot be used if factors affecting the competency referral are to be adequately understood. However, a meaningful pattern emerges from the present data—and would also probably emerge from the data of other studies—when the rate of referral as a function of the rate for each crime is calculated. Using this rate, one notes that the results of the present study are generally consistent with Matthews' hypothesis (4) that the strategies behind the competency referral will lead to an excess of referrals involving serious, violent, and atrocious crimes. The high rates of referral, particularly for homicide but also for sex crimes and robbery, support this hypothesis. The rate for assault does not seem to be as high as would be expected according to these strategies; the explanation for this probably lies in the extreme range in terms of seriousness that is included within the assault category. An interesting finding, not anticipated by any of us, was that the second highest referral rate was for arson. It is well known among persons who evaluate mentally ill offenders that arson is frequently related to psychopathology (14); it appears that judges and attorneys have also become aware of this.

Matthews noted three reasons behind the competency referral that would lead to high referral rates on these crimes: 1) to remove public pressure for severe punishment from the prosecutor, 2) to avoid a trial by jury on the responsibility issue, and 3) to provide a groundwork

TABLE 3
Frequency of Referrals by Crime and Type of Psychopathology

Crime	Psychosis	Personality Disorder	Other
Homicide	38	19	9
Arson	2	6	1
Sex crimes	17	13	5
Robbery*	11	20	3
Forgery-counterfeiting	4	10	0
Assaults	37	18	9
Stolen property	6	4	3
Weapons	8	2	1
Narcotics	2	6	3
Embezzlement	0	1	0
Burglary-larceny-theft	19	21	7
Totals	144	120	41

*Chi square significant at $p < .05$.

UNIVERSITY COLLEGE OF MEDICINE LIBRARY C. U.

TABLE 4
Frequency of Diagnosis by Geographical Source of Referral

Diagnosis	Area			Total
	Detroit	Outstate Urban	Rural	
Psychotic	99	28	17	144
Personality disorder	65	36	19	120
Other	30	6	5	41
Totals	194	70	41	305

for a not guilty by reason of insanity plea in crimes likely to result in long sentences. These bases for the competency referral are supported by the present data. The contentions by Hess and Thomas (3) that the referral may be a ploy for "undesirables for whom no other criminal disposition appears appropriate" and by Eizenstat (2), who suggested that it is a short circuit of the civil commitment procedures, with the implication that referral rates would be high for minor charges, are not supported by the present study.

The findings on the geographical distribution of referrals also provide information concerning the factors affecting the competency referral. Four crimes show a significant relationship between rate of referral and geographical source, but no easily interpretable pattern emerges. Overall, however, it is clear that the rate of referral is by far the highest for the Detroit area, and the rate is slightly higher for the outstate urban as compared to the outstate rural areas. Though police effectiveness is an uncontrolled factor here, the findings are generally consistent with our hypothesis that the proximity of facilities to urban areas and, more importantly, the greater knowledgeability of urban judges and attorneys produce a higher referral rate from urban areas. The implication of this finding is that outstate and, more particularly, outstate rural lawyers and judges are not making use of the competency referral in cases where their more sophisticated urban counterparts find a basis for doing so. Although the findings generally support a hypothesis of proximity, awareness, and knowledgeability of judges and attorneys as important factors affecting the competency referral, the four significant crime categories are not distributed according to the overall trend, thus supporting Hess and Thomas' hypothesis that jurisdictional ploys are also operating in some cases.

The results of the analysis of diagnoses indicate that the most frequent diagnosis is psychosis, although psychotics constitute slightly less than half of the total referrals. These findings place the Center for Forensic Psychiatry at the upper end in the distribution of referrals diagnosed psychotic among the studies in the literature. Although there are certainly nonpsychotic persons who are referred for competency evaluation because of a legitimate concern over their mental status, the proportion of psychotic diagnoses is a good barometer of the degree to which legitimate referrals are being made. Thus there is an indication that lawyers and judges in Michigan tend to abuse the competency referral less than lawyers and judges in other states. Even so, it is clear from the fact that more than half of the diagnoses are nonpsychotic that strategies rather than legitimate concern over mental status do indeed often motivate the competency referral.

Analysis of diagnosis within crime reveals a significant relationship only for robbery, where a higher than expected proportion are diagnosed as having personality disorders. The lack of a high frequency of psychosis in crimes such as homicide, arson, sex crimes, and robbery (where referral rates are high) is the strongest supporting evidence for the importance of strategies like those discussed by Matthews in determining referral rather than concern about mental status. The lack of a significant relationship between diagnosis and geographical source further suggests that this use of strategies is not limited to the Detroit lawyers. That is, while lawyers in Detroit and in other urban areas generally make more frequent referrals, rural lawyers, when they do make referrals, tend to do so on the basis of the same strategies. The rural lawyers use strategies proportionately as often as their urban colleagues, while making fewer total referrals—both legitimate and strategy-determined—in absolute terms.

CONCLUSIONS

Until the present study the literature on factors affecting referral for criminal competency evaluation has consisted largely of speculation or research studies whose methodological problems have led to uninterpretable or contradictory findings. The present research study, by analyzing the referral rate in terms of differential arrest rates by crime and geographical area, has provided more conclusive findings on the factors affecting the competency referral. In general, these conclusions are:

1. Referral is frequently based on some strategy rather than on a legitimate concern over mental status and therefore the rate of referral is not related to the seriousness of pathology.
2. The finding of high referral rates for serious, violent, and atrocious crimes indicates that these strategies usually involve attempts to remove public pressure for severe punishment, to avoid a jury trial on the responsibility issue, or to lay the groundwork for a not guilty by reason of insanity plea where the crime would result in a long sentence.
3. Proximity to the facilities and knowledgeability concerning the use of competency evaluation laws affect the total frequency with which referrals are made but not the proportion of referrals based on a strategy rather than on a legitimate doubt about competency to stand trial.

REFERENCES

1. Robey A: Criteria for competency to stand trial: a checklist for psy-

chiatrists. Am J Psychiatry 122:616–623, 1965
2. Eizenstat S: Mental competency to stand trial. Harvard Civil Rights-Civil Liberties Law Review 4:379–413, 1968
3. Hess JH, Thomas H: Incompetency to stand trial: procedures, results, and problems. Am J Psychiatry 119:713–720, 1963
4. Matthews AR: Mental disability and the criminal law: a field study. Chicago, American Bar Foundation, 1970
5. Balcanoff EJ, McGarry AL: Amicus curiae: the role of the psychiatrist in the pre-trial examination. Am J Psychiatry 126:342–347, 1969
6. Drummond G: Characteristics of 273 offenders referred for evaluation to the Department of Forensic Psychiatry, Jackson Memorial Hospital, August 1966 through December 1967. Southern Conference on Corrections Proceedings 15:23–31, 1970
7. Jablon NC, Sadoff RL, Heller MS: A unique forensic diagnostic hospital. Am J Psychiatry 126:139–143, 1970
8. Sadoff RL, Polsky S, Heller MS: The forensic psychiatric clinic: model for a new approach. Am J Psychiatry 123:1402–1407, 1967
9. Maxon LS, Neuringer C: Evaluating legal competency. J Genet Psychol 117:267–273, 1970
10. Cooke G: The court study unit: patient characteristics and differences between patients judged competent and incompetent. J Clin Psychol, April 1969, pp 140–143
11. Johnston NG, Jackson NLP, Schultz S: Psychodiagnosis in predicting determinations of competence to stand trial. Read at the meeting of the Midwestern Psychological Association, Detroit, Mich, May 6–7, 1971
12. Russell DH: Diagnosing Offender Patients in Massachusetts Court Clinics. International Journal of Offender Therapy, Offender Therapy Series Monograph 1. London, Association for Psychiatric Treatment of Offenders, 1971
13. Peterson W: Population. New York, Macmillan Co, 1969
14. Guttmacher MS, Weihofen H: Psychiatry and the Law. New York, WW Norton & Co, 1952

Questions of the Month

Directions: Each of the questions or incomplete statements below is followed by four or five suggested answers or completions. Select the *one* that is BEST in each case.

Question 1 The greatest incidence of first admissions to psychiatric hospitals occurs in which age range?

(A) 0–14 years
(B) 16–24 years
(C) 25–34 years
(D) 35–54 years
(E) over 65 years

Question 2 The tendency of an organizational unit to perform more effectively when it is studied is referred to as

(A) the Hawthorne effect
(B) the General Electric syndrome
(C) the law of effect
(D) the law of parsimony
(E) the Heisenberg principle

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are provided on page 880.)

Resentment and Suspicion Among American Men

BY MONICA D. BLUMENTHAL, M.D., PH.D.

A representative national sample of men between the ages of 16 and 64 were interviewed with respect to their levels of resentment and suspicion and their attitudes toward violence. Resentment and suspicion appeared to be related both to race and to social class. However, they were not related to attitudes toward the use of violence for gaining social control, suggesting that such attitudes are normative rather than expressive in nature.

ACCORDING TO THE FRUSTRATION HYPOTHESIS of aggression, frustration is likely to lead to anger and to an increased probability of hostile behavior (1). One might expect that frustration could also manifest itself in an individual as resentment and suspiciousness. A resentful and suspicious individual would be more likely than others to perceive threats in the environment. If it is true that aggression is provoked by perceived threats, resentment and suspicion would themselves lead to an increased level of aggressiveness. Since people tend to hold attitudes that are consistent with their behavior, one might expect resentful, suspicious individuals to have more positive attitudes toward violence than others.

Trust is often regarded as a basic personality trait that is determined early in life on the basis of the parent-child relationship. However, it seems reasonable to speculate that such trust may be modified by the experiences of the individual and by his life situation during adulthood. Suspicion and the closely allied phenomenon of resentment may be regarded as the converse of trust.

In a national survey of attitudes toward violence conducted in summer 1969, a sample of American men were asked a series of questions measuring resentfulness and suspiciousness. This paper considers the results of this survey and the extent to which resentment and suspicion are related to external circumstances in the sample.

METHOD

A random, representative sample of men, ages 16–64, who were living in the coterminous United States were interviewed in the summer of 1969. Blacks were sampled at a higher rate than other respondents so that there was a total of 303 black respondents. All data describing the population as a whole were weighted so that black men were not overrepresented in the analysis. Interviewing was conducted by professional interviewers from the Survey Research Center of the University of Michigan, using a structured interview schedule. Coding was carried out according to the methods standard at the Survey Research Center (2).

The primary aim of the interview was to assess attitudes toward violence (3), particularly attitudes toward the use of violence as a means of maintaining social control and as a tool for producing social change. A good part of the interview dealt with the measurement of these two attitudes and with such related material as the respondent's values, his attitudes toward people involved in violence, and the types of behaviors he defined as violent.

The items used to measure resentment and suspicion were the resentment and suspicion subscales of the Buss-Durkee Hostility Inventory (4). The 18 items in these subscales were loaded on a single factor in Buss's original analysis and appeared to have a high face validity for measuring the constructs.

The items (see appendix 1) were used to measure resentment and suspicion in two pretests involving 42 and 40 respondents, respectively. Additional data on 12 of the 18 items were obtained from a study carried out by Cobb (5) in which he measured these characteristics in a population of 80 men who were interviewed before and after losing their jobs. The six items used in interviewing the national sample were selected from the original 18 on the following basis: 1) items should not be extremely skewed in their frequency distribution for either blacks or whites; 2) both the resentment and the suspicion subscales should be equally represented; 3) items should be highly related to the central concepts—that is, they should show either high interitem correlation, or 4) they should show a distinct way of measuring central concepts. The six items and the frequency of positive responses to them by the sample as a whole and by blacks and whites specifically are shown in table 1.

In order to combine these items into a single index, we wished to assure ourselves that the index would be equally valid for a variety of subpopulations in the national sample. Consequently, the stipulation was made that the items should bear the same relationship to each other in a number of these subpopulations. To assure that this condition would be met, correlation between items was calculated for whites, blacks, individuals with some college education, and individuals with less than an eighth-grade education. In addition, interitem correla-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Blumenthal is Program Director, Survey Research Center, Institute for Social Research, University of Michigan, Ann Arbor, Mich. 48106, where she is also Associate Professor of Psychiatry.

TABLE 1

*Percentage of Positive Responses on Resentment and Suspicion Items for American Men**

Item	White (N = 1,046)	Black (N = 303)	All Men** (N = 1,374)
I don't seem to get what's coming to me	11	46	15
I am sometimes eaten up with jealousy	21	28	22
I get a raw deal out of life	32	62	36
I tend to be on my guard with people who are somewhat more friendly than expected	49	67	52
I wonder what hidden reason another person has for doing something nice for me	34	55	36
I used to think most people told the truth, but now I know otherwise	44	65	47

*Missing data were excluded in calculating the percentages in this and in all following tables. Unless otherwise noted, the missing data comprise less than one percent of the sample.

**In the sample 25 persons were neither black nor white but were classified as "other," which included Orientals, American Indians, Chicanos, etc.

tions were calculated for those with high and low incomes, those living in the south, those younger than 25, and for the population as a whole.

This analysis demonstrated that there was some inconsistency in the relationships between the item "Although I don't show it, I am sometimes eaten up with jealousy" and the remaining items. For this reason, that item was not included in the index of resentment and suspicion. The remaining five items were coded and summed into the Resentment-Suspicion Index. The higher the respondent's score on the index, the greater the number of resentful or suspicious responses he had given (6).

RESULTS

It can be seen from table 1 that 52 percent of all of the men stated that they tend to be on their guard with "people who are somewhat more friendly than expected" and that almost half agreed with the statement "I used to think most people told the truth, but now I know otherwise." Only 15 percent of the men thought that the statement "I don't seem to get what's coming to me" was true, but four times as many blacks as whites agreed with this statement. Similarly, while only 36 percent of all men thought the statement "At times I feel I get a raw deal out of life" was true for them, almost twice as many blacks as whites thought so. In fact, the black men responded positively to all the items more frequently than the whites, although the greatest difference in the distribution of responses was for those items derived from the resentment rather than from the suspicion subscale.

Relationship Between the Index and Demographic Characteristics

Table 2 shows the relationship between the Resentment-Suspicion Index and social class (as defined by Hollingshead [7]), education, income, age, and race. It can be seen that there was a definite relationship between social class and attitudes of resentment and suspicion—the lower the social class the higher the score on the index. This was not due to the disproportionate number of blacks in the lowest social classes since the relationships still held when the analysis was conducted among white men only. The same results were obtained when resentment and suspicion were correlated with education and income—the less the individual's education or income, the more likely he was to be suspicious and resentful. By far the most substantial relationship concerned race, blacks being much more inclined than whites to agree with items that indicated suspiciousness or resentfulness.

Table 3 shows the relationship between social class and the Resentment-Suspicion Index separately for the two races. Here the three highest social classes were combined, since the number of blacks in upper classes was too few to permit comparison. Black men were only half as likely as white men to fall into the lowest category of the Resentment-Suspicion Index even when only the highest social classes were considered.

The relative numbers of blacks and whites in the three highest social classes presented an interesting insight into the possible cause for such differences. Only eight percent of the blacks fell into these three classes, as opposed to 27 percent of the whites. This substantial difference is a concrete example of the disadvantaged position blacks occupy, and one can readily imagine that such a disadvantaged state could lead to resentful and suspicious attitudes.

The relationships between resentment and suspicion and demographic characteristics might have been expected on the basis of a priori considerations. Although trust is often thought to be a fundamental personality trait, there is ample reason to believe that trust and its converse, resentment and suspicion, can be influenced by the life situations of the individual. It seems reasonable that gross measures of a person's current circumstances, such as social class, education, and income, could be re-

TABLE 2

Relationship Between Resentment-Suspicion Index and Selected Demographic Characteristics

Item	Gammas	
	All Men	White Men
Hollingshead socioeconomic index	-.3	-.3
Education	-.3	-.3
Income	-.2	-.2
Age	-.1	—
Race	.5	—

TABLE 3
Frequency of Responses on the Resentment-Suspicion Index According to Race and Social Class (in Percentages)

Social Class	Number*	Resentment-Suspicion Index Low 1–2	Low 3–4	High 5
High				
White	346	65	30	5
Black	26	42	29	29
Medium-low				
White	429	43	47	10
Black	77	20	37	43
Low				
White	144	36	40	24
Black	114	12	41	47

*No students were included in these data since it was not possible to classify them accurately according to the Hollingshead schema. Consequently, the total number in this analysis is only 1,136.

lated to his perceptions of the world. It is true in our culture, as in many others, that the lower the individual's social class, the less status he is likely to have and the more likely he is to be subject to such traumatic and unhappy events as job loss, death, illness, and chronic stresses such as financial insecurity.

One might expect these conditions to cause an individual to adopt a more resentful and suspicious view of life than is characteristic of those who have had better circumstances. The differences between blacks and whites can be explained along a similar vein. In addition to the fact that in the United States blacks are less likely to be well educated and to hold prestigious jobs and are more likely to be poor, they are more likely to have experienced numerous unpleasant events as a result of discriminatory attitudes and practices that have been prevalent in this country. Therefore it is not surprising to find that blacks are more likely to obtain high scores on this index than whites even when adjustments are made for social class.

The last demographic characteristic that we wish to consider in some detail is marital status. Table 4 shows that persons who were separated at the time of the study were more likely to score high on the Resentment-Suspicion Index than others in the population. Those least likely to score high on the index were married.

TABLE 4
Distribution of Resentment and Suspicion According to Marital Status (in Percentages)

Marital Status	Number	Resentment-Suspicion Index Low 1–2	Low 3–4	High 5
Single	257	36	46	18
Divorced	31	45	33	22
Married	1,049	48	39	13
Widowed	17	69	17	14
Separated	20	17	33	50

TABLE 5
Relationship Between Scores on Resentment-Suspicion Index and Respondent Cooperation (in Percentages)

Item	Number	Resentment-Suspicion Index Low 1–2	Low 3–4	High 5
Not cooperative	17	27	26	47
Somewhat cooperative	207	38	36	26
Very cooperative	1,143	46	41	13

Other demographic characteristics investigated in this study, such as religion, region where interviewed, or foreign background, showed only minor relationships to suspiciousness and resentment after differences due to race had been taken into account.

Trust, Cooperation, and Identification with Police

The Resentment-Suspicion Index related a number of other characteristics the study measured in ways indicating that the measure assessed the intended dimension. The index was negatively related (gamma = –.5) to a three-item index measuring trust (see appendix 2). In every case where the Resentment-Suspicion Index related to another variable, the Trust Index related equally but in the opposite direction, thus suggesting that the Resentment-Suspicion Index and the Trust Index are on the same dimension (which should be the case since suspiciousness is the converse of trust).

There was also a relationship between the extent the interviewer judged the respondent as uncooperative and the respondent's scores on the Resentment-Suspicion Index (see table 5). Table 5 implies that the index is related not only to the respondent's attitudes, but also to his behaviors in the interviewing situation. This is what one might expect since resentful, suspicious people might find it more difficult to trust the interviewer sufficiently to be able to cooperate well in the interviewing process.

During the interview, the respondents were asked a set of questions measuring their identification with the police. They were asked: 1) whether they thought the police were helpful or were looking for trouble, 2) whether they were trustworthy or whether one couldn't "be too careful" in dealing with them, 3) whether they were likely to dislike persons like themselves, and 4) whether life was likely to change for the better or for the worse if the police achieved their goals. Those American men who were more resentful and suspicious were less likely to identify positively with the police than others. The more resentful the individual, the more likely he was to think the police were untrustworthy and "looking for trouble." (The average gamma on the police identification items was –.2 for both whites and blacks.) Again, it seems reasonable to conclude that people who show a general

set of suspiciousness are less trusting of specific groups, particularly when the groups are composed of authority figures such as the police.

Resentment, Suspicion, and Attitudes Toward Violence

During the interview, each respondent was asked how much force he felt was necessary to maintain social control. Specifically, the interviewer asked how often certain police actions should be used in controlling disturbances in three situations. The first disturbance was described as a scene in which hoodlum gangs caused property damage and terrified some citizens; the second specified a campus disturbance in which students were causing property damage; and the third disturbance was described as an inner-city riot. In each case the respondent was asked whether the police should: 1) let it go and not do anything, 2) make arrests "without using clubs or guns," 3) "use clubs but not guns," 4) "shoot but not to kill," or 5) "shoot to kill." The respondent could respond to each of these alternatives with "almost always," "sometimes," "hardly ever," or "never."

The responses were scaled and combined into the Violence for Social Control Index. The higher the score on the index, the more frequently the respondent thought it necessary to use more violent police actions. (Details of the scaling are presented elsewhere [3].)

There was no relationship between scores on the Resentment-Suspicion Index and the Violence for Social Control Index either for the total sample or for white or black men separately. So, it appears that there is no relationship between an individual's resentfulness and suspiciousness and his views on the use of violence as a tool for maintaining social control.

The respondents were also asked how much property damage and personal injury they felt would be necessary to produce social change "fast enough." Again, the respondent was asked his opinion about the necessity of using violence to produce social change in three different situations—first, with respect to the changes needed by students; second, with respect to the changes needed by blacks; and last, with respect to change in general. These responses were combined into a single scale, the Violence for Social Change Index.

The higher the respondent's score on this index, the more he agreed that property damage and personal injury were necessary to bring about rapid change. Scores on the Resentment-Suspicion Index were related to attitudes toward violence for social change among all of the men (see table 6). Further analysis indicated, however, that the relationship between the Resentment-Suspicion Index and the Violence for Social Change Index was, in fact, only true for white men (gamma = .2) and that no such relationship prevailed for black men.

These findings concerning the relationship between attitudes toward violence and resentment and suspicion were somewhat different from what we had expected a priori. Our initial notion had been that the more resentful and suspicious the individual, the more likely he would be to espouse views that would justify all kinds of violence.

TABLE 6

*Relationship Between Advocating Violence for Social Change and Scores on Resentment-Suspicion Index (in Percentages)**

Resentment-Suspicion Index	Number	Violence for Social Change		
		Low	Middle	High
1 (low)	296	57	34	9
2	267	53	35	12
3	306	39	43	18
4	244	39	38	23
5 (high)	254	23	38	39

*Gamma = .3.

The reasoning underlying this hypothesis was that an individual was likely to have attitudes and values that would enable him to express his personality traits.

The fact that our results did not conform to this hypothesis requires some explanation. A number of alternatives are available. One possibility is that personality traits do not influence values and attitudes. This seems unlikely; a wealth of information indicates that personality structure is profoundly related to attitudes and values. The choice of occupation provides a classic example; it is unlikely that an individual who is not at all meticulous and compulsive would undertake a profession such as accounting.

A second possibility is that attitudes toward violence are so greatly determined by cultural influences and perceived normative values that individual personality traits have little influence in determining them. There is some evidence in our data which indicates that this speculation might be correct. Our data indicated that the use of violence as a means of maintaining social control has widespread acceptance in this country. It could be regarded as a normative value. We found that these attitudes are not related to resentment and suspicion. On the other hand, the use of violence as a means of producing social change is not a normative belief among American men in general, although it approaches such status among black men, about half of whom believe that some property damage and personal injury are necessary to bring about change at a reasonable rate.

As already noted, we found that the Resentment-Suspicion Index was related to white men's attitudes toward violence in our population but not to black men's. If our speculation about the relationship of personality traits and normative beliefs is correct and if in the future the use of violence as a means of social control becomes less widely accepted, a greater relationship should occur between resentment and suspicion and attitudes about violence. If, on the other hand, attitudes toward the use of violence to produce social change become more widely accepted among American men in general, correlations between resentment and suspicion and such attitudes would decrease. In any case, the current data are not sufficient to test this hypothesis, the validity of which remains to be determined by future research.

REFERENCES

1. Berkowitz L: Aggression: A Social-Psychological Analysis. New York, McGraw-Hill Book Co, 1962
2. Muehl D: Manual for Coders: Content Analysis. ISR no 298, 1961 (processed). Available upon request from Publications Division, Institute for Social Research, University of Michigan, Ann Arbor 48106
3. Blumenthal MD, Kahn RL, Andrews FM, et al: Justifying Violence: Attitudes of American Men. ISR no 3296. Ann Arbor, Institute for Social Research Publications, 1972
4. Buss AH, Durkee A: An inventory for assessing different kinds of hostility. J Consult Psychol 21:343–349, 1957
5. Cobb S: Personal communication, 1968
6. Blumenthal MD, Andrews FM: Resentment and suspicion. ISR no 3316, 1972 (unpublished). Available upon request from Publications Division, Institute for Social Research, University of Michigan, Ann Arbor 48106
7. Hollingshead AB: Two-factor index of social position. New Haven, 1965 (processed)

APPENDIX 1

Items on the Resentment-Suspicion Subscales of the Buss-Durkee Hostility Inventory

RESENTMENT SUBSCALE

1. I don't seem to get what's coming to me.
2. Other people always seem to get the breaks.
3. When I look back on what's happened to me, I feel resentful.
4. Almost every week I see someone I dislike.
5. Although I don't show it, I am sometimes eaten up with jealousy.
6. I don't know any people that I downright hate.
7. If I let people see the way I feel, I'd be considered a hard person to get along with.
8. At times I feel I get a raw deal out of life.

SUSPICION SUBSCALE

1. I know that people tend to talk about me behind my back.
2. I tend to be on my guard with people who are somewhat more friendly than I expected.
3. There are a number of people who seem to dislike me very much.
4. There are a number of people who seem to be jealous of me.
5. I feel that others are laughing at me.
6. My motto is "Never trust strangers."
7. I commonly wonder what hidden reason another person may have for doing something nice for me.
8. I used to think that most people told the truth, but now I know otherwise.
9. I have no enemies who really wish to harm me.
10. I seldom feel that people are trying to anger or insult me.

APPENDIX 2

Trust Index

1. Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?
2. Would you say that most of the time people try to be helpful or that they are mostly just looking out for themselves, or they aren't one way or the other?
3. Do you think most people would try to take advantage of you if they got a chance or would they try to be fair?

Answers to Questions of the Month

Page 875. Question 1: E; Question 2: A.

Illnesses of the Spirit Among the Serer of Senegal

BY MORTON BEISER, M.D., WINTHROP A. BURR, M.D., JEAN-LOUIS RAVEL, PH.D., AND HENRI COLLOMB, M.D.

This report is part of an extensive survey of the Serer tribe in West Africa; the purpose is to assess clinical characteristics and prevalence of psychiatric disorder. Using key-informant interviewing, the authors identified three "illnesses of the spirit" as corresponding in many ways to Western notions of mental illness. Case material is presented that provides impressionistic evidence of the universality of some mental disorders.

AS FAR AS IS KNOWN, some concept of mental illness is part of every culture. That is, there seems almost always to be a portion of the set of deviant behavior or emotion that is considered indicative of sickness as opposed to criminality, eccentricity, rebelliousness, creativity, or unpleasantness. There has been a long-continued argument over whether the category of mental illness reflects culturally defined norms only (1, 2) or whether it represents, to some extent at least, a universal recognition of certain disorders, whether biologically or socially determined, that occur everywhere (3).

While it is obvious and undeniable that mental illness is culturally defined, the extent to which it is culturally determined is in doubt. For schizophrenia, at least, there is good evidence that genetic factors are important (4), and syndromes hauntingly similar to schizophrenia have been reported in many parts of the world (5–10). The syndrome clearly differs from culture to culture, however, not only in psychotic manifestations but also probably in terms of course and prognosis (11, 12).

At another end of the spectrum there are certain syndromes—e.g., latah, amok, pibloktoq, koro, imu, and windigo (8, 10, 13–16)—that seem to be restricted to single cultures or cultural levels and that are hard to fit into Western nosology, even given its extraordinary plasticity. On the other hand, it is important to note that some reported cases with the above labels *do* fit Western notions of pathoplastic, hysterical, or schizophrenic illness (8). Although speculation with regard to these disorders has centered on social causes (11, 16), organic theories have not been entirely neglected (17).

Thus one may propose that some mental illnesses have a culture-free basis and others seem much more culture-bound, but the weight of evidence is not so great that even this timid position is protected from attack. The data base in cross-cultural psychiatry is not yet extensive or reliable enough to allow broad generalizations and global inferences. There is need for reliable quantitative research, to be sure, but the importance of qualitative descriptive work as a basis for the generation of hypotheses should not be overlooked at this stage. It is in the spirit of qualitative, descriptive addition to the knowledge of mental illness in a non-Western culture that we present the following cases of illness among the Serer of Senegal. As does any cross-cultural experience, this not only elucidates something about primitive conceptions of mental disorder but also raises questions about our own assumptions concerning these phenomena.

This report represents part of the earliest phase of an extensive survey of the Serer tribe to assess the clinical characteristics and prevalence of psychiatric disorder. The survey methods involved gathering social data, data from physical examinations, laboratory studies, psychiatric interview data, and reports of subjective states as recorded by questionnaire. A pilot phase involved compiling a lexicon of local disease terms and studying a sample of people labeled by the Serer as suffering from behavioral disorder. The results were used to help in the design of a survey questionnaire and in standardizing psychiatric ratings (18).

DESCRIPTION OF THE POPULATION

The survey was done in the county of Niakhar in the Sine-Saloum region of Senegal, a West African nation that became independent from France in 1961. The Serer ethnic group makes up 95 percent of the county population (some 35,000). There are 65 villages ranging in size from 55 to 2,563 persons, with a median size of about 400 (18). The land is low and flat, the soil arid, and the population dense (85 persons per square kilometer). There is a nine-month dry season and a three-month rainy season.

The Serer are a group of 595,000 settled agriculturists, a large portion of whose territory encompasses the Sine-Saloum region. Although the origins of the group are obscure, elements have been traced from Mauritania and the Upper Nile. In the Sine-Saloum region, centuries of domination by the Mandingue tribe from French Guinea have given rise to a rigid feudal caste system, which has been largely preserved to this day (19, 20). In general, observers have been most impressed with the great stability

Dr. Beiser is Associate Professor of Social Psychiatry, Harvard School of Public Health, 55 Shattuck St., Boston, Mass. 02115. Dr. Burr is resident in psychiatry, Massachusetts Mental Health Center, Brookline, Mass. Dr. Ravel and Dr. Collomb are with the University of Dakar, Senegal, where Dr. Ravel is Research Psychologist and Dr. Collomb is Professor of Psychiatry.

of the traditional Serer culture, especially in this region (18, 20). Kinship colors or determines all aspects of personal, economic, and religious life. Marriage is polygamous and is preferred between cross-cousins. Inheritance is bilateral and rigidly prescribed.

Farming is the chief occupation, with the keeping of livestock in a secondary role. Various grains are grown for subsistence; peanuts are a cash crop.

Although Islam and, to a much lesser extent, Christianity have made minor inroads, the main focus of religious life centers around the Pangols, which are ancestor spirits and personifications of natural forces. These often reside in sacred trees near the compounds and play a major part in daily life. Their blessings are needed for major undertakings. Failure to properly propitiate them is often invoked as a cause of illness, crop failure, and other misfortunes. There are other spirits, such as the Djinne, Olawo, and Nakh, that inhabit the air and water and that are also given responsibility for illness.

METHOD

Using key-informant interviewing (18), we identified the Serer category of "illnesses of the spirit" as corresponding in many particulars to Western notions of mental illness in that it consists of behaviors that bother the individual and/or others (21, 22), whose explanation is more or less uniform and goes beyond commonsense notions of motivation (23, 24), and that are thought to be treatable within a religio-medical context.

This of course is not the only possible approach. Another frequently used approach is to begin with Western syndromes of disorder and to search for equivalents in another culture (7, 24). While this is an important step in laying the groundwork for cross-cultural studies in epidemiology, our purpose in this report is somewhat different. The major category, "illnesses of the spirit," omits certain behaviors and syndromes that are of psychiatric interest, some of which Western diagnosticians would see as frank evidence of illness. Some of these have been described elsewhere (18, 19, 25) and will be reported further. In limiting our purview here to what the Serer themselves define as illness, we hope to raise some important questions about the process through which people within a given culture become defined as sick rather than otherwise deviant or receive no official recognition at all, even though Western psychiatrists and laymen alike might consider them ill.

A total census of adults considered to be suffering from illnesses of the spirit in the 65 villages of the region was undertaken. A sample of 50 was drawn from this census, stratified so as to ensure representation in each category of illness. Each subject was then interviewed on two occasions, once by a psychiatrist from the psychiatric hospital at Dakar (the capital of Senegal), and once by a trained interviewer using a Serer translation of the questionnaire developed by the Leightons and their colleagues in the Stirling County study (7, 26). This questionnaire elicits both somatic and affective symptomatology. The order of these two interviews was varied at random.

The format of the investigation departed from the usual Western one in that the interviews were rarely conducted with the subject alone. There was usually a more senior member of the family present. Standard Serer behavior prescribes that questions be answered by the senior member of the kinship system up to the limit of his knowledge, after which he defers to the actual subject. This applied more to the psychiatric interview than to the questionnaire session and resulted in more material coming from the subjects' families than from the subjects themselves. Also, the psychiatric interviews were conducted through interpreters, which seems to have reduced the amount of information obtained.

In all, 32 cases were successfully worked up in this way. Some of the original 50 refused one or both interviews. In several cases data were lost in the field. Because of the limitations of space, only selected cases from the 32 are presented.

CASE REPORTS

There are three major types of illnesses of the spirit—O'Bodah, O'Dof, and M'Befedin.

O'Bodah

Literally O'Bodah means someone with no idea in his head, one who thinks like a child, talks to himself, and is easily influenced. Sometimes this can develop from a case of O'Dof. The diagnosis of O'Dof versus O'Bodah is disputed at times by various healers.

Case 1. This approximately 40-year-old widow had been speaking strangely for about eight years. She did not answer questions, but her son described her as talking like a child, talking too much, and being prone to say embarrassing or insulting things. She did not seem to talk to Pangols or people who were not there, to use unknown words, or to be openly hostile or vicious. She seemed to know who everyone was, was a practicing Moslem, and was generally clean and conventional in her habits, although one person in the community noted that she had been denudative on occasion.

Her affliction was a source of shame for the family and prevented her from remarrying. She had been to many local healers and had been treated with both medication and charms to tie on her body (*gris-gris*). The family felt she may have improved somewhat in the past two years. Her son answered her questionnaire and said she sometimes felt inferior to others, was uninterested in things, and showed a lack of initiative. In addition she was prone to feeling restless without knowing why and complained of difficulty keeping her thoughts straight. She also complained of occasional nausea, headache, and nightmares.

Case 2. This 55-year-old converted Catholic, who was head of the family compound and had three wives, had an illness that had started suddenly about ten years earlier. He was primarily a farmer but did masonry on the side. One day he had gone to a nearby village to build a well. He felt something must have been done against him in his home village after he left that resulted in an attack by Nakhs (anthropophagic spirits), because when he got where he was going and started work on the well, the people he met were quarrelsome and picked fights with him. That

night, while sleeping in the other village, he awoke suddenly, having seen something frightening that he could not remember. He felt a chill and felt his hair standing on end. Then a cat came into the hut and jumped on his chest. He ran out of the hut to catch it, but it was nowhere to be seen.

There followed a period of two months in which the patient was kept bound in his house. He was denudative and assaultive to everyone. He was covered with dirt. At this time he was considered Dof.

Following these two months, he was less agitated and, although still quarrelsome, was not assaultive. He was unbound, but "couldn't talk right" and was the subject of ridicule. He ate poorly, lost weight, and was subject to nightmares, but he continued to function as family head. He converted to Catholicism at about this time. This period of the illness was called O'Bodah.

No one in his family had ever had a similar illness. At the time of the study he considered himself cured. Except for occasional frightening dreams, headaches, and an occasional day of discouragement, he felt well.

O'Dof

O'Dof corresponds closely to the English words "mad" or "crazy." Symptoms include agitated, destructive behavior and habit deterioration. Although the diagnosis itself does not seem to be associated with social opprobrium, victims are usually unable to carry out normal social functions and may be overly dependent on their families. Visual and auditory hallucinations, most commonly speaking with or hearing Pangols, are often reported. There are several kinds of O'Dof, distinguished etiologically and by symptoms. Types with a distinct etiology are *Dof Na Rog A Fina* (the man who is born insane or "made by God"), *Dof Otial Nawe* (due to Moslem spirit attack), and *Dof Pangol* and *Dof Djinne* (due to attack by Pangols or Djinnes, respectively). Types with distinct symptomatology are *Dof O Fao Ker* (distinguished by quiet, noncombative behavior), *Dof Fada* (distinguished by aggression), and *Dof Adijia* (distinguished by a capacity for relatively normal speech).

The course is considered variable, and hope is held out for a cure through the placation of the appropriate spirits as well as through the taking of "medications" of various types. All the cases turned up in this survey had persisted for several years, and it was common to hear that many different healers had been consulted without effect. A very common course was one of several months or years of acute agitation and assaultiveness, giving way to a more tranquil but still often hallucinated, socially hypofunctional state.

Case 3. The illness of this 35-year-old divorced farmer had begun abruptly seven years previously. He had lived all his life in the village until the winter before his illness started, at which time he went to the city to find work. Shortly after his return to the village the following spring, he awoke with a start in the middle of the night crying, "Somebody made my soul leave me!" Then he ran out of the house into the bush and was pursued by his older brother, who bound him and brought him home.

For the next two years he could not sit still. He shouted and sang. He talked with Pangols. He tried to run off many times and did not seem to recognize his parents. Once he tried to hit his mother. Many healers were called in; they disagreed as to whether the cause was Nakhs, Djinnes, or Pangols and prescribed numerous medications. At one point he spent four years living in a healer's compound in another village with his mother.

All this, the family felt, produced a change in him so that he became quiet and no longer assaultive. At the time of the study he rarely spoke to anyone except his mother, and then only to say good morning or to ask for cigarettes and cola nuts. He lived in his father's house and still worked in the fields, but he had to be told when to stop or he would work himself to exhaustion. He often required urging to eat and occasionally still seemed to talk to Pangols. He had an occasional angry outburst when he would tear up some bedding, usually when he went looking for his mother and did not find her at home.

He did not speak to the interviewer; his father said that he seemed to have no complaints apart from his illness but that he did not seem interested in life and seemed hopeless some days.

Case 4. The patient, the 15-year-old son of the village chief, had gotten sick suddenly about six years previously. People felt he must have seen a Djinne when he went to the well one evening, because that night he had the first of a series of attacks characterized by tonic-clonic movements and rolling eyes, followed by unconsciousness lasting about one hour and associated with amnesia. He has continued to have these attacks about once or twice a month.

He was taken to the Catholic priest and several of the local healers. The healers agreed that it was an unusual case of *Dof Djinne.* M'Befedin, which is the usual category invoked for seizures, was ruled out. This was because no foam had been seen coming from his mouth that might contaminate others. The father sacrificed to the Pangols and even moved his house in accordance with the direction of a local healer, but the attacks continued. They have not interfered with the patient's normal life, however, and he was able to go through circumcision and initiation with his age-mates.

At the time of the study the patient felt quite well except for occasional dizzy spells and restlessness.

M'Befedin

Sufferers of M'Befedin ("those who swoon") are subject to periodic attacks characterized by falling, thrashing movements of the limbs, tongue biting, incontinence, and especially foaming at the mouth. Many get burns from falling into cooking fires.

M'Befedin is felt to be contagious through the saliva of affected people, a notion shared by other African tribes (21, 27). This theory results in considerable social isolation of sufferers, who usually sleep in separate houses and eat with separate utensils. Marriage is out of the question. If a young boy gets the illness, he is not allowed to take part in the circumcision ceremony, which robs him of his status as a man and of important quasi-kinship relationships with his age-mates undergoing circumcision together.

There is an occasional flexibility, as in the case of one young woman who developed the illness after she had married and had several small children. She was allowed to stay with the children and even to sleep with her husband.

In case 4 above, which was labeled O'Dof, most of the

features fit the category of M'Befedin except that foaming at the mouth was not observed. Since this patient was the eldest son of a chief, the O'Dof diagnosis was the more benign one in terms of disruption of the family structure and lines of succession. One cannot help but wonder whether foaming at the mouth was ignored or not perceived in this case as a result of a part of the diagnostic process that Edgerton (28) called negotiation between society and its healing sector. He suggested this negotiation can affect the perceptions of the diagnostician.

Case 5. This patient, a 20-year-old unmarried Moslem man whose mother was unhappy because he had "lost his soul," began having nocturnal attacks of trembling, with urinary incontinence and foaming at the mouth, about three years previously. The elders diagnosed it as M'Befedin.

The fits increased in frequency, and the family noted that the patient did not speak as well as he had formerly, in spite of much treatment by traveling healers.

The attacks were reported to be most frequent at the beginning and end of each month. They were often accompanied by headaches and vomiting, and the patient's disposition was said to suffer during periods when they were frequent. His family answered his questionnaire and noted that he had dizzy spells and sweaty hands and feet, was often anorexic, and was given to expressing feelings of hopelessness, inferiority, indecision, and confusion in his thinking.

He apparently had had a normal childhood and worked as a shepherd, as all boys do. He did not attend school. He was never circumcised because the onset of his illness forced its postponement.

At the time of the interview he was spending his time at home, eating apart and drinking from his own cup. He could not work and had practically no hope of marrying. He was often taunted by his younger brothers and other small children, and at the time of the interview was dressed as a girl.

There was no family history of any similar problem. The family believed it resulted from an attack by Pangols.

Case 6. The patient, a 27-year-old single farmer, started having attacks with foaming at the mouth at the age of about one year. When they started, his parents noted that he was feverish much of the time, and after about two or three months they took him to a healer who diagnosed O'Bokh, an illness said to result from the mother's having passed a place where a dog was killed during her pregnancy.

After he was weaned, the designation of the illness changed to M'Befedin. He continued to have fits with urination and foaming at the mouth, most commonly during the first ten days of each month. Seven months before the interview he went to the hospital at Dakar and got medication that stopped the fits until he ran out a few days before the interview, when they started again.

The patient was living in a house by himself and using his own eating utensils because of the fear that M'Befedin is passed through the saliva. He worked in the fields, but had no hope of marrying unless he was cured, which to the family would mean having no fits even while not taking medication. This was at least partly because his family said they could not afford both the bride price and the price of drugs.

His family noticed that when his fits were frequent he was short-tempered and difficult. He once threatened to hit his brother, but was stopped.

An EEG performed at the hospital in Dakar showed diffuse abnormality with low voltage over the right hemisphere.

DISCUSSION

The meaning of the mental illness label in our society has been a subject for lively discussion. Scheff (29) suggested that the label encompasses "residual deviance"—that which is left after immorality, criminality, eccentricity, etc., have all taken their cut of the deviant behavior. Hence there is no way to describe mental illness in unitary terms. Szasz (30), emphasizing another aspect of the same line of argument, insisted that mental illness is merely a role in which society casts certain people. Both arguments may be seen as variants of an extreme cultural relativist position.

If cultures as strikingly different as our own and the Serer identify exactly the same behaviors and emotional states as indicative of sickness, it might be a point of evidence in favor of a concept of mental illness as an entity independent of social labeling. If, however, there is no correspondence between what is categorized as illness in these two cultures, it would support a purely sociological approach to the problem since there is no reason to believe that what is considered deviant behavior should be the same in such radically different sociocultural contexts. What, then, is the degree of fit between illnesses of the spirit and mental illness?

The three major types of illness of the spirit, O'Bodah, M'Befedin, and O'Dof, seem on an impressionistic level to share the attribute of serious disability involving the whole of the person's social functioning. In the case of M'Befedin, a large part of this disability may be the result of the culture's response to the presumably organically caused symptoms, whereas in the case of O'Dof, the disability persists in spite of a cultural response that would seem less likely to compound it than would the response of ostracism and isolation found in many cultures confronted with similar behavior problems.

Thus there are parallels between illness of the spirit and psychosis that may be closer than those between illness of the spirit and mental illness in general. Both identify a total personality adaptation that is bizarre. In this way both categorizations differ from those which identify one or a few behavior patterns or actions without including the rest of the personality.

Another important feature of the Serer system is that it includes troublesome behavior within the illness category, but not states of subjective distress. The case histories make it quite clear that this does not mean that the Serer are immune to affective upsets, or that symptoms of what Western psychiatrists would probably call anxiety and depression do not occur. When they are discussed, such traits are considered characterological; they have no name in the religio-medical context. Some of the reasons for this difference in labeling have been suggested in previous reports, in which it has been noted that one aspect of diagnosis has to do with the possibility of, or at least a perceived need for, control (18, 24, 31). The possibilities here may be that chronic anxiety and depression do not interfere with the functioning of the social system to a degree that makes control imperative. From another vantage point, it is possible that the Western devel-

opments in psychotherapy and pharmacology raise hopes for control of these states through medical means (31). Serer medical technology does not arouse such expectations.

The best correspondence in illness concepts involves the category of M'Befedin, which fits wery well the set of seizure disorders of the grand mal type. But there is more to diagnosis than the taxonomy of symptoms, and the Western and Serer categories part company along two major lines. First, most seizure disorders are no longer considered mental illnesses in the Western world. Second, contagion and saliva are such an important part of the Serer diagnosis that they can apparently override other considerations, as in case 4. Thus we see a different process of weighting symptoms in assigning a diagnostic label. This differential weighting often results in what looks like unreliable observation as the reason for a lack of diagnostic agreement. In fact, the unreliability may not be at the level of observation but, rather, may be based on assumptions about the nature of illness and effective methods of control.

In the category of O'Bodah the Serer have formalized the problem of speech and thinking that do not make ordinary sense and that tend to be chronic and to interrupt the ordinary pattern of life. There is an associated aspect of passivity, childishness, or easy suggestibility. O'Dof is similar to O'Bodah as a category except that the additional nuance of violent or agitated behavior is usually part of the concept. These problems occur in the West but are classified differently. Encephalopathy, mental retardation, functional psychosis, etc., all come to mind. The patients we found would all clearly be ill in the Western sense even though we cannot diagnose them confidently, chiefly because of a lack of physical data. (The subsequent survey will include physical examinations.) But in some cases, especially case 3, the temptation to diagnose schizophrenia is all but irresistible.

Although the case material presented does not prove anything in and of itself, it does provide more impressionistic evidence about the universality of some mental disorders. Furthermore, some illnesses are probably universally recognized as such.

While the similarities in illness categories are striking, it would be a mistake to neglect the differences. For instance, although we can dispel the myth of the "happy savage" who knows no neuroses (7, 18, 25), there remains the problem of differing perceptions of this behavior. Have the Serer not evolved an illness category for this because neurotic behavior is actually less frequent among them than in Western societies, and thus there is less need for "official" recognition? Alternatively, is there less chance of being helped with a neurosis in a Serer village than in a Western city and hence no use in having a label?

Frequency of occurrence of a syndrome may account in part for official labeling, but this clearly does not apply to psychosis and epilepsy, which occur infrequently. What, then, are the factors that account for their universal recognition?

Clearly, the answers to such important questions depend upon further research. The occurrence of behaviors—including symptoms, the form in which they are categorized, and the decision to label them "illness" or some other form of deviance—are interdependent processes. Understanding illness in cross-cultural studies thus clearly calls for interdisciplinary work involving the combined efforts of clinicians and epidemiologists on the one hand and social scientists on the other.

REFERENCES

1. Benedict R: Patterns of Culture. Boston, Houghton Mifflin Co, 1934
2. Opler M: Culture, Psychiatry and Human Values. Springfield, Ill, Charles C Thomas, 1956
3. Savage C, Leighton AH, Leighton DC: The problem of cross-cultural identification of psychiatric disorder, in Approaches to Cross-Cultural Psychiatry. Edited by Murphy JM, Leighton AH. Ithaca, NY, Cornell University Press, 1965, pp 21–63
4. Rosenthal D, Kety S: The Transmission of Schizophrenia. New York, Pergamon Press, 1968
5. Eaton JW, Weil RJ: Culture and Mental Disorder: A Comparative Study of the Hutterite and Other Populations. New York, Free Press of Glencoe, 1955
6. Field MJ: Search for Security: An Ethnopsychiatric Study of Rural Ghana. Evanston, Ill, Northwestern University Press, 1960
7. Leighton AH, Lambo T, Hughes C, et al: Psychiatric Disorder Among the Yoruba. Ithaca, NY, Cornell University Press, 1963
8. Lin T: A study in the incidence of mental disorder in Chinese and other cultures. Psychiatry 16:313–336, 1953
9. Spiro M: Cultural heritage, personal tensions and mental illness in a South Sea culture, in Culture and Mental Health. Edited by Opler M. New York, Macmillan Co, 1959, pp 141–171
10. Wittkower ED: Transcultural psychiatry, in Modern Perspectives in World Psychiatry. Edited by Howells JG. Edinburgh, Oliver & Boyd, 1968, pp 697–712
11. Collomb H: Bouffées délirantes en psychiatrie africaine. Psychopathologie Africaine 1(2):167–239, 1965
12. Jilek WG, Jilek-Aal LM: Transient psychoses in Africans. Psychiatr Clin (Basel) 3:337–364, 1970
13. Landes R: The abnormal among the Ojibwa Indians. J Abnorm Soc Psychol 33:14–33, 1938
14. Rin H: A study of aetiology of koro in respect to the Chinese concept of illness. Int J Soc Psychol 11:7–13, 1965
15. Yap PM: Mental diseases peculiar to certain cultures: a survey of comparative psychiatry. J Ment Sci 97:313–327, 1951
16. Brill AA: Pibloktoq or hysteria among Peary's Eskimos. J Nerv Ment Dis 40:514–520, 1913
17. Wallace AFC: Mental illness, biology and culture, in Psychological Anthropology. Edited by Hsu FLK. Rosemond, Ill, Dorsey Press, 1961, pp 255–295
18. Beiser M, Ravel J-L, Collomb H, et al: Assessing psychiatric disorder among the Serer of Senegal. J Nerv Ment Dis 154:141–151, 1972
19. Ravel J-L: Some notes about an epidemiological survey in a region of Senegal. Department of Behavioral Sciences, Harvard School of Public Health, 1969 (unpublished manuscript)
20. Reverdy J: Une Societé Rurale au Senegal. Aix-en-Provence, Centre Africaine des Sciences Humaine Appliqués, 1963
21. Leighton AH, Murphy JM: The problem of cultural distortion, in Comparability in International Epidemiology. Edited by Acheson RM. Princeton, NJ, Milbank Foundation, 1964, pp 189–198
22. Dohrenwend BP, Dohrenwend BS: The problem of validity in field studies of psychological disorder. J Abnorm Psychol 70:52–69, 1965
23. Clements FE: Primitive concepts of disease. University of California Publications in American Archeology and Ethnology 32:185–252, 1932
24. Murphy JM, Leighton AH: Native conceptions of psychiatric disorder, in Approaches to Cross-Cultural Psychiatry. Edited by Murphy JM, Leighton AH. Ithaca, NY, Cornell University Press, 1965, pp 64–107

25. Beiser M: Definitions of mental illness in tribal Africa and rural North America. Read at the 70th annual meeting of the American Anthropological Association, New York, NY, Nov 18–21, 1971
26. Leighton DC, Harding JS, Macklin DB, et al: The Character of Danger: Psychiatric Symptoms in Selected Communities. New York, Basic Books, 1963
27. Jilek WG, Jilek-Aal LM: The problem of epilepsy in a rural Tanzanian tribe. Afr J Med Sci 1:305–307, 1970
28. Edgerton RB: On the "recognition" of mental illness, in Changing Perspectives in Mental Illness. Edited by Plog SC, Edgerton RB. New York, Holt, Rinehart & Winston, 1969, pp 49–72
29. Scheff TJ: The role of the mentally ill and the dynamics of mental disorder. Sociometry 26:436–453, 1963
30. Szasz TS: The Myth of Mental Illness. New York, Paul B Moebin, 1961
31. Kline NS: Bringing clinical services to underdeveloped countries and contributions to basic knowledge that can be expected from such enterprises. Acta Psychiatr Scand 38:170–175, 1970

The Manfred S. Guttmacher Award

The American Psychiatric Association invites applications for its annual Manfred S. Guttmacher Award for 1974. The award is given for any outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or any other work, including audiovisual presentations, submitted to or presented at any professional meeting or published during the year ending December 31, 1973. The award, which includes an honorarium of $250 and a plaque, will be presented at the Convocation of Fellows at the annual meeting in Detroit, Mich., May 1974.

Anyone who wishes may apply to receive the award by submitting five copies of the work as well as five abstracts to Jonas Rappeport, M.D., Chairman, Guttmacher Award Board, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Entries will be acknowledged but will not be returned.

The deadline for submissions is January 1, 1974, and any entry to be considered must be in Washington by that date.

The Practice of Hospital Psychiatry: A Formulation

BY GARY J. TUCKER, M.D., AND JERROLD S. MAXMEN, M.D.

Most psychiatric hospital treatment in this country has been based on the theories and techniques of the office practice of individual psychotherapy. As a result, if a patient requires hospitalization he is apt to automatically get "more of the same" type of therapy he received on the outside. Although it may be useful, this approach fails to distinguish between the goals and practices of outpatient versus inpatient treatment. The authors attempt to spell out a more rational basis for the use of psychiatric hospitalization.

WHY ANOTHER PAPER on hospital psychiatry? Any psychiatrist or mental health worker "knows" what to do in a hospital—that is, to do it either "my way" or the way "I was taught." Consequently there are numerous papers about training staff but few articles that question the goals and purposes of hospitalization itself. Furthermore, there are many claims about milieu therapy but few attempts to delineate what type of treatments or interventions are possible and useful in a psychiatric hospital and how they may differ from those used with outpatients.

It is the purpose of this paper to present a theoretical framework for psychiatric inpatient care. Although we recognize the complexities of the subject, we have sought to be definite and explicit, rather than tentative and guarded, in order to provoke thought and perhaps useful debate. It is hoped that this paper will enable people who work in hospitals to not only better define what they are doing, but further enhance the unique potential of the psychiatric hospital. We feel this is especially important because we have been repeatedly struck by the discrepancy between what hospital psychiatrists say they do and what they actually do.

In writing this paper we have drawn upon our collective observations of more than 30 hospitals throughout the United States as well as an extensive survey of the literature. The characteristics of these facilities, which we have described elsewhere (1), differ considerably according to length of patient stay, patient to staff ratios, utilization of the milieu, theoretical orientation, and treatment modalities.

In this paper we will confine ourselves to discussing the short-term psychiatric hospital, by which we mean an inpatient program where the average length of stay is from three to 12 weeks. This is to be distinguished from crisis intervention units on the one hand and long-term treatment centers on the other. Each of these latter two forms of hospitalization obviously necessitates a different theoretical orientation. Furthermore, we are limiting our discussion to the American psychiatric hospital. Maxwell Jones, who has worked on both sides of the Atlantic, has shown how the numerous distinctions between American and British psychiatry have necessitated differences in hospital structure and treatment (2).

THE PRESENT STATE OF PSYCHIATRIC HOSPITAL TREATMENT

"Fifty years ago the superintendent of the state hospital was the representative psychiatrist; today it is the private practitioner" (3). This shift in focus has had significant but generally unrecognized implications for the practice of hospital psychiatry. Since the great thrust of psychiatric training until recently has been designed for those who ultimately would enter private outpatient practice, relatively little theoretical or experimental interest has been directed toward psychiatric hospital treatment.

This state of affairs has emerged in this country from a peculiar series of circumstances. Psychiatric units associated with major university training centers are usually organized so that trainees can most readily be schooled in the principles that their teachers know best, e.g., the office practice of psychoanalytic psychotherapy. Therefore the resident's supervision most often concentrates on therapy cases that are devoid of those sticky administra-

The authors are with the Department of Psychiatry, Dartmouth Medical School, Hanover, N.H. 03755, where Dr. Tucker is Associate Professor and Dr. Maxmen is Assistant Professor.

tive issues and complicated reality factors which so often interfere with the free and uninhibited flow of psychodynamic exploration. On the other hand, while state hospital trained psychiatrists are frequently the most skilled at treating the more severe psychiatric disorders, they have little opportunity to theorize, research, and publish their treatment endeavors. Thus it is not surprising that most of the important innovations in hospital treatment (e.g., therapeutic communities and sheltered workshops) have come from Europe, where psychiatric practice has been more hospital based.

In recent years American psychiatrists, excited over the prospect of a new approach to inpatient treatment, have totally accepted the therapeutic community concept. As a result, supposed milieu treatment centers have suddenly blossomed throughout the land without discretion or discrimination. They lack any overall conceptual framework, and patients are subjected to a hodgepodge of activities from basket weaving to basketball. Interrupted only by a daily dose of individual psychotherapy and four daily doses of medication, this nonprogram has become the staple of many of our so-called therapeutic communities.

Although every inpatient unit says that it has a therapeutic community or milieu therapy, nobody agrees on what it actually is, for these terms may mean anything from homelike furnishings to elaborate behavior modification programs with token economies, etc. However, what it often appears to be is an unfortunate amalgamation of the distorted principles and ideas of Sigmund Freud and Maxwell Jones. For, in fact, most doctors and patients perceive the milieu and activities aspect of hospitalization as being considerably less significant and unrelated to the "real" work of individual psychotherapy. It should therefore come as no surprise that in this country much of what is considered "good" psychiatric hospital treatment is still based on the theories and techniques of the office practice of psychotherapy, and what a patient receives when he enters a hospital is in essence "more of the same." While this approach could be useful, it seems inadequate.

REASONS FOR HOSPITALIZATION

If we examine some of the frequent causes of hospitalization we are immediately confronted with the multiplicity of problems facing the hospital psychiatrist. What is found is that the manifest reasons for psychiatric hospitalization are usually a variance or combination of the following: 1) a failure of all other interventions, with an increase in symptoms or maladaptive behavior to a disabling level; 2) failure to clarify a diagnostic problem; 3) failure of the environment (therapist, family, work) to further tolerate the patient's behavior, or its persistent reinforcement of the previous maladaptive behavior; 4) failure to institute a new form of treatment that requires careful medical and/or psychiatric supervision; and 5) violent or destructive behavior to self or others (1, 4–6). While these represent only the most common reasons for psychiatric hospitalization, it is striking that none of them overtly and primarily involves intrapsychic dynamics. Instead, patients enter a hospital because of their conscious awareness of feeling uncomfortable or as a result of familial or social pressures.

Despite this, it is not unlikely that a patient who enters the hospital because of increasingly violent arguments with his wife will be told, either overtly or covertly, "No, this is not your real problem; your real problems are your feelings about your mother." While this is most likely true, it is true at only a much deeper level—a level that would postulate an etiology clearly derived from a theory and require some rather prolonged and intimate therapy between patient and psychiatrist to document and treat. Although both the theory and treatment may be correct, adequate, and certainly the most traditional, they still present certain problems for the hospital psychiatrist: 1) time is limited; 2) the wife feels left out; 3) unless the wife or husband is completely restricted to the hospital the violence may continue; and 4) the patient may have been treated by a previous psychiatrist with a different theoretical orientation.

A FORMULATION FOR THE BASIS OF HOSPITAL TREATMENT

While the patient's overt behavior may present similar problems for the outpatient psychiatrist, they are frequently not as pressing as, for instance, in the case of an actual physical threat. In this and most cases the hospital psychiatrist must actively intervene—he must say something to the distraught family and show the patient that he can respond quickly and effectively to alleviate the patient's immediate distress.

Since the hospital psychiatrist initially knows comparatively little about the patient, the primary level of intervention should be based on his observations of the patient's behavior. Certainly, during the course of hospitalization the patient's behavior becomes more understandable to the psychiatrist. However, this knowledge should still only be used to help the hospital psychiatrist focus on the patient's overt behavior and interactions. More specifically, he should attend to that behavior which would allow the patient to return to independent functioning and thereby enable him to leave the hospital.

This is not to say that meaning and understanding are less important than the overt behavior, but only that treatment is a continuous process and hospitalization is but one phase of the treatment. As a phase in the treatment process, some techniques are more suited to it and should be differentiated from methods that may be more appropriate during latter phases of therapy.

Instead, what we propose for the practice of hospital psychiatry is a treatment based on a rehabilitation model, rather than one based on theories of the etiology of mental illness (7). By analogy, no one has ever believed that the techniques of speech therapy or physiotherapy are suitable for removing the vascular lesion responsible for a stroke or would be effective in preventing further cerebral

vascular accidents. Nevertheless, nobody doubts the value of such treatment. Similarly, in hospital psychiatry, although the practice of rehabilitation sounds less enticing than the quest for the ultimate cure, we believe that the former provides a more realistic, practical, and therefore more humane approach to inpatient care.

In essence we believe that the practice of hospital psychiatry must be pragmatic, empirical, and flexible so that patients will, it is hoped, survive whatever theoretical ax we have to grind. In part this is a nonetiological model, but only in the sense that to be helpful the treatment does not have to be linked to any etiological theory of mental illness. The psychiatrist does not have to "resolve the oedipal complex" or convince the patient that "relatives and friends cause schizophrenia," but only has to offer the patient what seems helpful and appropriate at the time. Nevertheless, in psychiatry more than any other medical specialty, etiologic theories do determine how treatment is conducted. In large measure this is because there is such a wide divergence in our theoretical notions about the etiology of mental illness. One only has to contrast the many varied approaches to the treatment of schizophrenia, from the strictly psychoanalytic to the exclusively biochemical, with those for duodenal ulcers, for which essentially the same therapy is universally employed.

We believe that some of the major difficulties in coupling treatment with an etiologic theory are as follows:

1. The treatment must be consistent with the theory, which then determines in great measure what can and cannot be treated. For example, Freud's early feelings about schizophrenics excluded this illness from the scope of psychoanalytic treatment.

2. A total commitment to any one theory of etiology and its accompanying treatments limits the therapist's range of interventions.

3. The goals of therapy often become the fulfillment of a theory rather than what the patient actually desires or needs. Many psychiatrists (and some patients as well) will object to this disassociation of etiology from treatment because it does not seem to get down to the so-called root of the problem. But the fact is that no psychiatric patient will be "cured" by short-term hospitalization.

If hospital treatment is cast in a rehabilitation model, then the prime goal of hospitalization is to alleviate, if not eliminate, the reason hospitalization was necessitated in the first place. This is not a simple goal, by any means, but it does present some criteria for termination of hospitalization, i.e., the patient may be discharged when he has returned to his optimal premorbid level of functioning. We should consider only this ability to function and not lifelong residual symptoms or unresolved psychodynamic conflicts. It is probably in this area that the goals of inpatient and outpatient treatment vary the greatest. But they also vary in that the patient is present for observation, treatment, and intervention 24 hours a day, and this very simple presence requires the hospital psychiatrist to devise a treatment technique that utilizes this physical presence.

DESIGN OF THE HOSPITAL MILIEU

The psychiatric hospital should be designed to fulfill these rehabilitative functions. The data for determining these interventions are primarily based on observations of the patient's transactions with staff, patients, friends, and family. It is perhaps in this area of interpersonal difficulties that the utilization, purpose, and specificity of psychiatric hospitalization is most evident. For it is impossible to assess and treat these varied interpersonal problems with only data from the dyadic relationship (8, 9). Therefore, if the psychiatric hospital is to adequately evaluate and treat those patients with transactional difficulties, it must provide varied interpersonal situations where such behavior can be observed and discussed. The very nature of an inpatient unit, with its large number of clients, readily facilitates different types of meetings, ranging from patient governments to small group therapies. Not to employ such differing therapeutic modalities, therefore, is to deprive the hospitalized psychiatric patient of optimal rehabilitation and the hospital staff of crucial information.

Evaluating the patient's premorbid environment should be of equal significance to the hospital staff (10). This assessment should include a detailed analysis of the patient's family, peer, school, or work situation in order to determine the stresses that have contributed to the patient's impaired functioning. Also, the people in this environment should be included in the evaluation, since they may often present a more accurate picture of the patient's premorbid behavioral functioning than the patient himself can.

In the design of a hospital program it is also essential to create an atmosphere that encourages patients to take active responsibility for themselves and others. In other words, instead of being the passive recipients of the staff's therapeutic efforts, the patients should assume the role of change agents. In this manner they are able to raise their already lowered self-esteem, counteract their regressive tendency, and realize that they still possess assets during a period of their lives when their failures would seem to predominate. Thus patient governments or simply involving patients in decisions about their own care and the care of others may be a positive influence, not because "democracy cures mental illness" or "psychopathology is caused by a lack of egalitarianism in our society," but rather because they can encourage and restore the patient's optimal social functioning.

WHAT TYPE OF TREATMENT CAN BE USEFUL IN THIS SETTING?

Certainly the use of medication is of considerable value because it can often mitigate or remove symptoms, allow evaluation and other forms of treatment to proceed, and in itself return the patient to a level of optimal premorbid functioning. In utilizing psychotropic agents, pragmatic considerations should prevail. Thus the schizophrenic would receive phenothiazines not because the psychiatrist

feels the disease is essentially a biochemical disorder, but rather because they are clinically effective. Furthermore, the patient should be an active participant in assessing and utilizing the particular drug prescribed. (By this we do not mean that the patient should decide on the dose or type of medicant being used, for this is clearly beyond his expertise.)

But most importantly in a setting where transactional skills and problems are stressed, the staff can help the patient increase his repertoire of adaptive skills. Whether this involves establishing and maintaining friendships, being responsible for one's actions, or coping with an alcoholic spouse, the hospital setting should provide a laboratory wherein the patient may safely experiment with newly acquired adaptive skills (11). The settings necessary to teach such skills must of necessity be highly varied, not only to facilitate greater information gathering, but also to permit the patient to generalize his responses from one treatment modality to another. Thus patients should be encouraged to apply what they learn from individual psychotherapy to group therapy and from the group setting to their family meetings, etc. For example, an adolescent who consistently baits his parents can practice more useful responses to adults in group therapy before trying them out in family conferences.

In teaching patients adaptive skills it is also necessary to construct ward activities that approximate realistic situations that patients would encounter in daily living. Specifically, peer relations can be demonstrated in group settings, and authority relations may be observed in staff contacts and family situations. The daily interactions with other patients and staff members of differing ages can all simulate life on the outside. In a similar vein, it should not be the goal of hospitalization to minimize or eliminate stress, since the fact is that stress is an integral part of daily living with which the patient must learn to contend. At the same time, patients should also be expected to act appropriately and consistently with the optimal social functioning they are capable of at that particular time. And finally, in order to impart adaptive skills the ward program should allow patients to become aware of the transactional impact of their behavior as well as to identify behavior similar to their own that is reflected in the actions of others. Thus in large measure the rehabilitation process should be an educational one.

As noted previously, hospitalization is one phase in the therapeutic process. While we find that a hospital treatment approach based on overt behavior and emphasizing adaptive skills is effective (12–15), several additional tasks must be undertaken in preparation for the patient's discharge.

The hospital treating short-term patients should help them establish a treatment contract. This would include teaching the patients to view issues from a psychological perspective, to identify stressful situations, and to help them focus on a hierarchy of treatment issues for present and future treatment. Of equal importance is the necessity for the hospital psychiatrist to evaluate which patients can best utilize which type of therapy, to indicate this to the patient, maximize its use, and recommend it for outpatient care. Indeed, this is still another reason for the psychiatric hospital to provide a wide variety of treatment modalities, for only with such technical eclecticism can the effectiveness of differing therapies for individual patients be properly evaluated.

Furthermore, since the behavior of family members may greatly influence the patient's well-being, the psychiatrist should attempt as much as possible to get all those in the environment to become allies of the treatment team, thus avoiding undercutting the treatment program (9). It is to be hoped that the staff will not hesitate to treat those family members or pathological family interactions which, after proper assessment, seem to interfere with the patient's ability to function. Failing in this, the staff and patient must often consider some rearrangement of the environment. Although this calls to mind "manipulation," one of the common dirty words of psychiatry, it is extremely important to clarify and alleviate the difficulties in the patient's environment before he is discharged. This involves short structured passes to the new environment he is going to, in order to see what notable points of stress may exist.

THE ROLE OF STAFF

The implementation of this vast range of therapeutic observations and their accompanying interventions necessitates a full-time staff who can ensure overall integration of the total program. An effective inpatient treatment center also requires that the therapeutic skills of each staff member become maximized. While this obvious principle of hospital psychiatry is generally recognized, it often tends to become abused in two ways:

1. In a strong medical hierarchy, physicians may act as if only they can help the patient and that all other staff-patient contacts are of little consequence. Frequently statements such as "Only the psychiatrist understands the unconscious" and "The patients always perceive the doctor as the only vital person in their treatment" have justified the minimization of the nonpsychiatrists' therapeutic involvement.

2. In reaction to this medical dominance there has developed a kind of pseudo-egalitarianism where "everybody should do everything" regardless of training or skills. The fact is that social workers, psychiatrists, and nurses, for example, all have different training and thus develop their own unique set of valuable skills. Not only should such skills be encouraged, but it is necessary that ongoing educational programs exist for every discipline and not just psychiatric residents.

And finally, while it may be in vogue to believe that only if the staff solves its own problems can the patients improve, one should not forget that the hospital is for the patients and not the staff.

SUMMARY AND CONCLUSIONS

Most "good" psychiatric hospital treatment in this

country has been based on the theories and techniques of the office practice of individual psychotherapy. As a result, if a patient requires hospitalization he is apt to automatically get more of the same type of therapy he received on the outside. Although this may be useful, this approach fails to distinguish between the goals and practices of outpatient versus inpatient treatment. This paper has attempted to spell out a more rational basis for the utilization of psychiatric hospitalization.

In essence we propose that the basis for psychiatric hospital treatment be primarily empirical, e.g., to treat what the patient presents to us about himself and his environment. In part this is a nonetiological model, in the sense that to be helpful the treatment does not swear allegiance to a particular etiologic theory. Since patients are usually hospitalized because they are unable to function, it should be the major aim of hospitalization to restore their functioning. Thus the task of inpatient treatment is not to cure the patient, but to rehabilitate him. The primary data for this rehabilitation approach must be the patient's manifest transactional difficulties, since it is these difficulties that usually precipitate his hospitalization. It is perhaps in this area that the utilization, purpose, and specificity of psychiatric hospitalization becomes most evident. For example, while the goals of outpatient care may be to alter the underlying character structure of an individual, the purpose of inpatient treatment is to return the patient to his premorbid level of functioning.

In order to accomplish this the hospital staff should address itself to these four areas:

1. They should minimize symptoms by whatever means available in as short a time as possible.

2. After evaluating the patient's transactional behavior, it is important to expand the patient's repertoire of adaptive skills. This can be facilitated by utilizing various therapeutic settings that approximate conditions the patient will encounter once he leaves the hospital.

3. It is necessary to evaluate and to rearrange the patient's environment in order to alleviate any serious pressure he may encounter after discharge.

4. Finally, it is important to maximize the patient's ability to utilize outpatient therapy. This includes evaluating which modality of treatment is most suitable for the patient, teaching him to view problems psychologically, and helping him to determine the priority of treatment issues.

In psychiatry more than in any other medical specialty, the physician's personal theory of etiology determines treatment. The goals and tasks of psychiatric hospitalization and discharge—an area of treatment that has hitherto been inadequately examined—require much more analysis. Although we know little about inpatient therapy, this paper attempts to construct a latticework upon which we may be able to better understand the hospitalization process.

REFERENCES

1. Maxmen JS, Tucker GJ: The admission process. J Nerv Ment Dis 156:327–340, 1973
2. Jones M: Social Psychiatry in Practice. Baltimore, Pelican, Penguin Books, 1968
3. Hollingshead AB, Redlich FC: Social Class and Mental Illness. New York, John Wiley & Sons, 1958
4. Linn EL: The association of preadmission symptoms with the social background of mental patients. Arch Gen Psychiatry 8:129–134, 1960
5. Mendel W, Rapport S: Determinants of the decision for psychiatric hospitalization. Arch Gen Psychiatry 20:321–328, 1969
6. Wood EC, Rakusin JM, Morse E: Interpersonal aspects of psychiatric hospitalization, II: some correlations between the admission circumstances and the hospital treatment experience. Arch Gen Psychiatry 6:55–61, 1962
7. Detre T, Tucker GJ: Psychotherapy for the mentally ill: a redefinition of goals, in The New Hospital Psychiatry. Edited by Abroms G, Greenfield NS. New York, Academic Press, 1971, pp 57–65
8. Hes JP, Handler SL: Multidimensional group psychotherapy. Arch Gen Psychiatry 5:70–75, 1961
9. Tucker GJ, Maxmen JS: Multiple family group therapy in a psychiatric hospital. Journal of Psychoanalysis in Groups 4:27–34, 1972
10. Wood EC, Rakusin JM, Morse E: Interpersonal aspects of psychiatric hospitalization, I: the admission. Arch Gen Psychiatry 3:632–641, 1960
11. Abroms GM: Defining milieu therapy. Arch Gen Psychiatry 21:553–560, 1969
12. Soskis DA, Harrow M, Detre T: Long-term follow-up of schizophrenics admitted to a general hospital psychiatric ward. Psychiatr Q 43:525–534, 1969
13. Almond R, Keniston K, Boltox R: The value system of a milieu therapy unit. Arch Gen Psychiatry 19:545–561, 1968
14. Almond R, Keniston K, Boltox R: Patient value change in milieu therapy. Arch Gen Psychiatry 20:339–351, 1969
15. Bromet EJ: The posthospital adjustment of psychiatric patients. New Haven, Conn, Department of Public Health and Epidemiology, Yale University School of Medicine, 1971 (unpublished doctoral dissertation)

Judgments of Alternatives to Hospitalization

BY STEVEN H. LIPSIUS, M.D.

The author compared staff and hospitalized patients' judgments as to the avoidability of hospitalization by means of alternative treatment facilities. There was surprising validity in most patients' opinions concerning their hospitalization, as judged by agreement with staff opinions and experimental findings, except for affective psychotics, who overestimated avoidability. The author compares the specific alternatives selected by patients and staff and identifies factors affecting their judgments.

THE TREND TOWARD hospitalizing patients suffering from severe mental disorders, which started in the 16th century, began to be reevaluated in recent years. In 1936 Querido (1) documented that admissions of mental patients to hospitals were often unnecessary. Following World War II, which produced an excessive strain on psychiatric hospital facilities, numerous experiments were made to test the efficacy of alternative outpatient treatment. The most famous of these was the Worthing experiment, in which three British psychiatrists—Carse, Panton, and Watt (2)—were able to achieve substantial reductions in admissions, all before the introduction of modern drugs.

The community psychiatry movement has adopted as one of its major goals the avoidance of unnecessary hospitalizations by alternative outpatient and partial hospitalization programs. Although wide application of psychopharmacological drugs and a move away from custodial care toward more active treatments and employment of the therapeutic milieu have achieved a reduction in the state hospital population since 1955, this has been accomplished mainly through the discharge of long-term patients and shorter stays for newly admitted patients. Awareness of the resulting revolving-door type of patient flow pattern has stimulated the next major effort, which has been to intercept the flow of patients to the hospital in the first place by using alternative facilities where appropriate.

Studies such as those by Mishler and Waxler (3), Jones and associates (4), and Baxter and associates (5) focused on the decision to admit or not. Mendel and Rapport (6) included in their study the question: "If the social situation were different would you hospitalize this patient at this time?" They found that 84 percent of the 110 patients would not have been hospitalized according to the decision maker if the social situation had been different.

When facilities serving as alternatives to hospitalization attempted to treat patients who would ordinarily have been hospitalized, they achieved good results as long as they did not limit themselves by overdetermined criteria for alternative treatment, such as occurred in the study by Sampson and associates (7). Greenblatt and associates (8) were able, by alternative treatment, to keep almost half (49.4 percent) of their waiting-list patients out of the hospital during a two-year follow-up period. Pasamanick and associates (9) were able to keep approximately 60 percent of their patients, who had actually been sent to a mental hospital, out of the hospital for at least two years.

None of these studies considered the patient's opinion of his needs, other than his applying for admission. Even where the patient's opinions and preferences could not be taken into account by experimental necessity, they were, in addition, not recorded. The main reason for neglecting the patient's opinion in assessing the need for hospitalization seems to be the assumption that the mental patient, being in a state of mental disorder, is not capable of rendering a competent opinion on anything, let alone what might be the best treatment modality. However, Braginsky and associates (10) have demonstrated that schizophrenic patients not only are aware of their environment and motivationally oriented but can manipulate their environment a great deal and produce impressions on the staff in keeping with their goals—for newcomers, often to get out of the hospital, and for old-timers, to stay in the hospital. In addition, Klein and Fontana (11) demonstrated that "schizophrenic patients can be accurate sources of information" in their study of long-term patients in a Veterans Administration hospital and other patients in state hospitals. Only Keup (12), in a study of a chronically hospitalized population, evaluated both the patients' and staff's attitudes toward hospitalization. However, he analyzed the results individually and failed to match patients and staff.

The experimental studies utilizing random selection failed to record the staff person's judgment as to whether or not hospitalization was avoidable by alternative treatment. In addition, none of the studies dealt with a complete range of alternatives to hospitalization.

This study was undertaken to evaluate and compare patient and staff judgments as to the avoidability of hospitalization by alternative treatment, to determine fac-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

At the time this work was done Dr. Lipsius was Postdoctoral Fellow in Social and Community Psychiatry, Yale University; he is now Assistant Professor of Psychiatry, George Washington University School of Medicine, 2150 Pennsylvania Ave., N.W., Washington, D.C. 20037.

The author wishes to thank Jules Coleman, M.D., Edward Klein, Ph.D., Harry McNeill, Ph.D., and Robert Miller, M.D.

TABLE 1
Patient-Staff Agreement-Disagreement Concerning Avoidability of Hospitalization by Alternative Treatment

Item	Patient Judgment		Total
	Yes	No	
Staff judgment			
Yes	40	18	58
No	20	8	28
Total	60	26	86

tors affecting their judgments, and to compare selections from the full range of alternative treatment modalities.

METHOD

This study was of 106 patients consecutively admitted to Fairfield Hills (state) Hospital from the greater Bridgeport area of Connecticut from December 8, 1970, to January 18, 1971. Each patient and the staff member responsible for his care, usually a third-year psychiatric resident, were asked to complete a questionnaire inquiring as to whether or not they felt the patient's hospitalization could have been avoided if alternative treatment facilities had been available. A list of alternative modalities of treatment was included, and they were asked to check those alternatives they felt most appropriate, if any. The questionnaire was administered to the patients and staff as soon after admission as possible; the patients completed the questionnaire an average of three days following admission and the staff, 5.8 days.

Admission-form data consisted of demographic factors (this part of the form was completed by the intake worker) and problem appraisal data (completed by the admitting physician).

The patient population included all patients admitted to the hospital from the designated area except for patients sent to the drug-dependent and alcoholic units and children under 14 years of age.

RESULTS

Patients and staff similarly judged that approximately two-thirds (69 percent and 66 percent, respectively) of the patients' hospitalizations could have been avoided by alternative treatment.

When patient and staff judgments were matched for the 86 instances in which both rendered judgments (19 patients refused or were not able to, and one staff member was undecided), there were 40 patient-yes, staff-yes agreements (46 percent) and eight patient-no, staff-no agreements (9.2 percent), for a total agreement of 55.2 percent, which could have happened by chance alone. Of the disagreements, there were 20 patient-yes, staff-no and 18 patient-no, staff-yes responses, there thus being no patient bias favoring the avoidability of hospitalization. (See table 1.)

When patient and staff judgments were compared according to the patients' diagnosis, agreement was found for all diagnoses except the affective psychoses, for which 89 percent of the patients felt their hospitalizations were avoidable, compared to 45.4 percent of the staff ($p<.05$). (See table 2.) An analysis of the reasons given by the patients and staff reveals a wide discrepancy, the staff feeling that the patients were too confused or psychotic and unmanageable, while the patients felt they were the victims of a misunderstanding and not sufficiently disturbed to warrant hospitalization.

If the 12 patients with affective psychoses are excluded, reanalysis of the patient-staff agreement-disagreement figures reveals that patients and staff did agree significantly more ($p<.05$) than they disagreed about which patients' hospitalizations could and could not have been avoided by alternative treatment facilities.

Patient and staff judgments about the avoidability of hospitalization for the other diagnostic categories ranged from 89 percent and 100 percent respectively for the personality disorders, through 58.3 percent and 55.2 percent respectively for schizophrenia, to 60 percent and 46.1 percent respectively for the psychoneuroses. A comparison of these figures with the differential success rate by diagnosis in Greenblatt and associates' alternative treatment experimental study (8)—in which they found that hospitalization was not required by 75 percent of the nonpsychotics, 40.5 percent of the schizophrenics, but only 25 percent of the affective psychotics—reveals comparable figures for both patient and staff judgments, except for the affective psychotic patients, who have thus overestimated the avoidability of their hospitalizations.

Of the 38 demographic and problem appraisal factors whose relationships to patient and staff judgment were investigated, two were found to be significantly associated with both patient and staff judgment, seven with staff judgment only, and five with patient judgment only. (See table 3.) Expected findings included severity of ill-

TABLE 2
Comparison of Patient and Staff Judgments of the Hospitalizations Avoidable by Alternative Treatment, by Diagnosis

Diagnosis	N	Hospitalization Avoidable (Percentage)	
		Patient Judgment	Staff Judgment
Schizophrenia	29	58.3	55.2
Affective psychoses	12	89.0	45.4*
Organic brain syndrome	10	71.5	90.0
Psychoneuroses	13	60.0	46.1
Personality disorders	10	89.0	100.0
Alcoholism	17	66.7	76.5
Drug dependence	16	60.0	66.7
Other diagnoses	9	66.7	77.8

*Significant at the $.05<p<.025$ level; $\chi^2 = 4.85$; d.f. = 1.

TABLE 3
Relationship of Patient Demographic Factors and Problem Appraisal Factors to Staff and Patient Judgment of Avoidability of Hospitalization

Judgment*	Significance
Significant relationship to both staff and patient judgment	
Severity (inversely associated)	
Staff	$p<.001$
Patient	$p<.025$
Social relations disturbances	
Staff	$p<.05$
Patient	$p<.05$
Significant relationship to staff judgment only	
No prior psychiatric service	$p<.01$
First admission	$p<.05$
Living alone	$p<.025$
Diagnosis	$p<.05$
Eating problems	$p<.05$
Depressed, moody, or has feelings of inferiority	$p<.05$
Inappropriate affect, appearance, or behavior	$p<.05$
Significant relationship to patient judgment only	
Duration of illness (inversely associated)	$p<.01$..
Length of hospitalization felt needed (inversely associated)	$p<.001$
Suicidal acts or gestures	$p<.05$
Ethnicity (blacks)	$p<.05$
Agitation, hyperactivity	$p<.05$

*No significant relationship with either staff or patient judgment: sex; age; legal status; town; veteran; religion; marital status; social class (according to Hollingshead and Redlich's two-factor index); referral source; physical function disturbances; intellect; social performance disturbances; suicidal thoughts; anxiety, fears, phobias; obsessions, compulsions; somatic concerns, hypochondriasis; suspicion, feelings of persecution; delusions; hallucinations; anger, belligerence, negativism; assaultive acts; alcohol abuse, antisocial attitudes and acts; disorientation, impaired memory; slowed up, lack of emotion.

ness inversely associated with the judgment of avoidability of hospitalization by patients and staff, no prior psychiatric service and first admission by staff judgment, and duration of illness and length of hospitalization felt needed, both inversely associated with patient judgment.

The number of previous admissions was not included in this study, but it has been found by Phillips (13) to be significantly associated with the staff decision to admit a patient into the hospital.

That social relations disturbances, but not social performance disturbances, were positively associated with avoidability of hospitalization indicates that when the conflict spreads from interpersonal relationships with significant persons to disturbances in tasks in the job, school, or in the household, both patients and staff are more pessimistic about the avoidability of hospitalization.

The unexpected finding that patients who lived alone were judged by the staff as more likely to have an avoidable hospitalization than those who lived with one or more people appears to be explainable only by the conclusion that many persons living alone would probably not have been admitted to the hospital in the first place if they had had others to live with. The fact that diagnosis was associated only with staff judgment supports the position that staff *does* take the patient's diagnosis into account in making dispositions. The only physical function disturbance that was significantly associated with staff judgment was eating problems, which probably is related to its occurrence as an expression of depression in many patients who are not suicide-prone. The positive association of depression, moodiness, and feelings of inferiority with staff judgment as to avoidability of hospitalization probably reflects the positive prognostication of the patients' ability to verbalize mood and feelings. An unexpected finding, which I am unable to explain, is the positive association between inappropriate affect, appearance, or behavior and the staff's judgment in favor of avoidability of hospitalization.

Among the important unexpected findings was the positive association between patient judgment of avoidability of hospitalization and suicidal acts or gestures but not suicidal thoughts. The most likely explanation is that when patients had suicidal thoughts, they were more accepting of hospitalization since they had not yet expressed these thoughts in action.

The finding that significantly more black patients (11 out of 12) than white patients (23 out of 48) felt that their hospitalizations were avoidable demands explanation. The fact that the total percentage of blacks in the sample (11.3 percent) is less than the total percentage of blacks in the population (16 percent for the greater Bridgeport area) supports the explanation that only the healthier black patients enter the hospital, which is most distant from the area of the greatest density of the black population. The positive association of agitation or hyperactivity with the patients' judgment that hospitalization was avoidable may be explainable simply by the dislike of the confinement of hospitalization by patients with increased motor activity.

Although negative findings will not be discussed, two do warrant special mention. That social class was not significantly associated with hospital avoidability cannot be interpreted as evidence against the Hollingshead-Redlich finding that higher percentages of lower-class patients were hospitalized because the range of patients by social class was too narrow and skewed toward the lower classes, there being 42.3 percent of class V, 40.4 percent of class IV, 11.5 percent of class III, 5.8 percent of class II, and no class I patients. The surprising finding that legal status was not significantly associated with the judgment of hospital avoidability, by either patients or staff, indicates that the apparent objectivity of patients admitted on physicians' emergency certificates seems to have been underestimated. However, there was a trend in the direction of these involuntary patients, who constituted 57.5 percent of the patient population, feeling that their hospitalizations were avoidable ($\chi^2 = 2.88$, d.f. = 1, $p = .10$).

Patients and staff agreed, with two exceptions, as to the most important alternative treatment facilities necessary for the avoidance of hospitalization. In order of decreasing frequency they are: outpatient psychotherapy, halfway houses, day treatment, family counseling, home care, and sheltered workshops. The only two alternative treatment selections in which disagreement between patients

and staff reached significance were night treatment facilities ($p < .005$), selected mainly by the staff, and welfare ($p < .05$), selected mainly by the patients. One might conclude from this that the patients need education as to the utilization of night treatment facilities and the staff needs to be more aware of the importance of economic factors, at least from the patients' viewpoint. There was a nonsignificant trend for the staff to prefer halfway houses more than the patients and for the patients to prefer sheltered workshops more than the staff.

While no patient judgments of alternative facilities were specific for diagnostic category, staff judgments were in five instances. Day treatment, night treatment, and halfway houses were selected as an appropriate alternative modality for a significantly high percentage of schizophrenic patients. Similarly, home care was selected for patients with organic brain syndrome, and family counseling was chosen for patients with personality disorders.

A comparison of the patient and staff judgments as to length of hospitalization felt needed revealed that patients felt that they required briefer hospitalizations than the staff felt they needed (significant at the $p < .05$ level).

DISCUSSION

This study can be understood in the context of an opinion survey in which the opinions of the providers and consumers of psychiatric hospitalization are compared. They both agree that a significant percentage of psychiatric hospitalizations are avoidable by alternative treatment facilities. This is consonant with psychoanalytic postulates of conflict-free ego functions, as well as the notion of partial or selective regression. In addition, they both agree on all but two of the wide range of alternatives to hospitalization necessary to more effectively accomplish the goal of reducing the number of admissions to psychiatric hospitals.

Although the staff responses were made an average of several days later than the patient responses, there was no change when the results were reanalyzed, excluding the few much later staff responses responsible for the difference in the means. Consistency of staff responses is supported by the finding of no significant difference ($p = .134$) between the judgments made by the five staff raters, three of whom were third-year residents, one a first-year resident, and one a psychiatrist.

The single most important conclusion is that judgments made by patients, even though they are acutely disturbed, are much more valid (as measured against staff judgments and against actual experimental findings) than might have been expected, with the exception of judgments made by patients suffering from affective psychotic disorders, who tend to overestimate the avoidability of their hospitalizations. The clinical significance of this is that the psychiatrist deciding upon admission versus alternative treatment can validly take into account the opinion of the non-affective-psychotic patient.

REFERENCES

1. Querido A: Home Care of the Mental Patient. London, Oxford University Press, 1936
2. Carse J, Panton NE, Watt A: A district mental health service: the Worthing experiment. Lancet 1:39–42, 1958
3. Mishler EG, Waxler EG: Decision processes in psychiatric hospitalizations: patients referred, accepted, and admitted to a psychiatric hospital. Am Sociol Rev 78:576–587, 1963
4. Jones NF, Kahn MW, Langsley DG: Predictor of admission to a psychiatric hospital. Arch Gen Psychiatry 12:607–610, 1965
5. Baxter S, Chodorkoff B, Underhill R: Psychiatric emergencies: dispositional determinants and the validity of the decision to admit. Am J Psychiatry 124:1542–1548, 1968
6. Mendel WM, Rapport S: Determinants of the decision for psychiatric hospitalization. Arch Gen Psychiatry 20:321–328, 1969
7. Sampson H, Ross D, Engle B, et al: A Study of Suitability for Outpatient Clinic Treatment of State Mental Hospital Admissions, Research Report No 1. Sacramento, State of California Department of Mental Hygiene, 1957
8. Greenblatt M, Moore RF, Albert RS, et al: The Prevention of Hospitalization: Treatment Without Admission for Psychiatric Patients. New York, Grune & Stratton, 1963
9. Pasamanick B, Scarpitti FR, Dinitz S: Schizophrenics in the Community. New York, Appleton-Century-Crofts, 1967
10. Braginsky BM, Braginsky DD, Ring K: Methods of Madness: The Mental Hospital as a Last Resort. New York, Holt, Rinehart and Winston, 1969
11. Klein EB, Fontana AF: Understanding the schizophrenic. Int J Soc Psychiatry 15: 141–149, 1969
12. Keup W: The home-concept of psychotic patients and the prevention of chronic hospitalization. Psychother Psychosom 17:23–33, 1969
13. Phillips L: Case history data and prognosis in schizophrenia. J Nerv Ment Dis 117:515–525, 1953

DISCUSSION

JORGE DE LA TORRE, M.D. (Topeka, Kans.)—Dr. Lipsius' interesting idea in his study has been to compare the opinions of staff and hospitalized patients in arriving at a decision about these patients' hospitalization. His study also emphasizes how patients, even when disturbed enough to need psychiatric hospitalization, are more capable than is usually assumed of having useful points of view in such an important decision. This is quite consonant with psychoanalytic postulates of conflict-free ego functions and also with the notion of partial or selective regression.

At the beginning of his paper Dr. Lipsius indicates that one of the major goals of community psychiatry is to avoid *unnecessary* hospitalization by finding other viable alternatives. I would like to stress this point because it would be a mistake to assume that hospitalization is a bad thing and that alternatives are necessarily better. The patient would be as shortchanged by being hospitalized when his problems could be effectively dealt with in outpatient psychotherapy as he would be if a precise indication for hospitalization were missed. After all, one should keep in mind that prevention of hospitalization is a means and that the prevention or amelioration of psychiatric illness is the real end.

Dr. Lipsius' paper would have been even more meaningful if he had explained the process of screening the patients for admission. If admissions take place by means of rigid administrative channels, with very little room available for assessment of the patient's condition, one could imagine that both patient and staff could correctly agree that many of those admissions were unnecessary. On the other hand, if such a diagnostic process takes place one has to wonder what factors are responsible for the inaccuracy of that diagnostic assessment and decision-

making process. Greenblatt and associates (1) indicated in their study of community extension services that 25 percent of the patients they successfully treated presented "urgency rather than gravity of problems." Another 33 percent of the patients they successfully treated were referred for hospitalization because they were not acceptable to any of the existing outpatient facilities in the Boston area. This is just an indication how the decision for hospitalization is a function of the facilities available in the community, among many other variables.

Another issue that requires further clarification is the degree of experience of the clinician who made the decision for admission. They were primarily residents, but their level of training was not mentioned. As Mendel and Rapport (2) have indicated, there is a significant difference between clinicians with less than six months and more than three years of experience, with the clear tendency of the less experienced clinician to lean more heavily toward hospitalization. Also, with the pressure of dealing with very anxious and disturbed patients, more expertise and resourcefulness are needed in order to find other alternatives to psychiatric admission. In this connection it was not specified if the clinician making the decision for admission was the same one who later followed the patient during treatment.

Another point that I would like to comment on is the fact that the questionnaires were not completed immediately. This raises a question in my mind: After the initial crisis, anxiety, and potential danger (3) had diminished, how much did patients tend to minimize the situation while the staff became aware of assets that they could not see at the time the decision for admission was made?

I am not sure whether the alternative facilities mentioned in the questionnaire were actually available. Even more intriguing is how the patients could differentiate with any degree of accuracy between the various facilities, such as halfway houses, family care, and sheltered workshops.

In regard to Dr. Lipsius' finding that for the group of patients with suicidal attempts preceding hospitalization, hospitalization was felt to be more avoidable than for those with suicidal thoughts but no actual attempts. One could infer that more impulsivity, less ability to delay the discharge, and less observing ego available in the former group could in part explain the findings. The interesting finding about one particular diagnostic category, affective psychosis, remains puzzling.

Finally, I would like to express my agreement with Dr. Lipsius that we should be more receptive to utilizing the patient's own views in making our recommendation for hospitalization and that we should not underestimate his ability to use proper and effective judgment. I congratulate him in his effort to validate this opinion with this study.

REFERENCES

1. Greenblatt M, Moore RF, Albert RS, et al: The Prevention of Hospitalization: Treatment Without Admission for Psychiatric Patients. New York, Grune & Stratton, 1963
2. Mendel WM, Rapport S: Determinants of the decision for psychiatric hospitalization. Arch Gen Psychiatry 20:321–328, 1969
3. Baxter S, Chodorkoff B, Underhill R: Psychiatric emergencies: dispositional determinants and the validity of the decision to admit. Am J Psychiatry 124:1542–1548, 1968

Brief Hospitalization on a Crisis Service: A Study of Patient and Treatment Variables

BY W. RAY WALKER, M.D., LOWELL B. PARSONS, PH.D., AND W. DOUGLAS SKELTON, M.D.

The authors conducted a study of a brief hospitalization unit of a general hospital crisis intervention service to obtain empirical data on certain aspects of the patients and of the treatment services. They found that patients admitted to the unit had major psychiatric problems and that the same number with similar psychopathology were admitted during the day as during the night. Twice as many patients were discharged with plans for outpatient treatment than for inpatient treatment; these two groups differed on several dimensions of psychopathology. The authors discuss the implications of these findings for staff and treatment programs on such a unit.

THE PSYCHIATRIC SERVICES of metropolitan general hospitals receive many persons who are in an acute emotional crisis. In response to the demand for emergency psychiatric care some general hospitals have developed a crisis intervention service (CIS), the aim of which is to treat patients without removing them from the community. Treatment is based on the principles of prompt in-

The authors are all with Emory University School of Medicine, Atlanta, Ga., and with the Department of Psychiatry, Grady Memorial Hospital, 80 Butler St., S.E., Atlanta, Ga. 30303, where Dr. Walker is Chief Resident in Psychiatry and Drs. Parsons and Skelton are Assistant Professors of Psychiatry. Address reprint requests to Dr. Parsons.

tervention, identification of precipitating stresses, and formulation of treatment goals commensurate with short-term crisis therapy (1).

Several recent developments have expanded crisis services to meet a wider variety of patients' needs. One development is to continue treatment beyond the initial crisis period by using outpatient programs (2, 3). Another is the brief hospitalization unit (4), where patients can be briefly hospitalized while treatment plans are formulated, closely observed while additional information is obtained, and removed from stressful living situations; furthermore, in such a unit the effects of medication can be observed and adjustments can be made.

This study was designed to obtain empirical data on certain aspects of the patients and the treatment services in the CIS brief hospitalization unit of a general hospital that serves the greater Atlanta area. The special topics studied follow:

Psychopathology. One justification for the existence of a brief hospitalization unit is that it provides inpatient services on a short-term basis to seriously disturbed persons. Data were gathered to ascertain the psychopathology of patients on the unit.

Time of admission. Since patients were admitted around the clock, data were gathered to determine whether the number of admissions and their psychopathology varied with the time of admission.

Disposition. Some patients were transferred from the brief hospitalization unit to more extended inpatient programs. These patients were compared with patients referred to outpatient treatment for differences in psychopathology.

Return for outpatient appointment. Analyses were made to find out whether patients with outpatient appointments returned during the month after their discharge and whether returning for treatment was related to psychopathology at the time of admission.

METHOD

Successive admissions (N = 97) to the CIS brief hospitalization unit during a three-month period were evaluated in a standard psychiatric interview by one of us (W.R.W.). Of these patients, 22 failed to complete the interview for such reasons as excessive intoxication, withdrawn behavior, or organicity. Seventy-five patients (31 men and 44 women) completed the interview and constituted the sample studied. Their average age was 33.5 years and ranged from 17 to 70. The time of admission was divided into two periods: 6:00 a.m. to 5:59 p.m. (day) and 6:00 p.m. to 5:59 a.m. (night).

In the interview, patients were asked whether they had been treated in the past for emotional problems either as an inpatient or as an outpatient. The interviewer recorded his impressions of the patient on the Inpatient Multi-Dimensional Psychiatric Scale (IMPS) by Lorr and Klett (5). This scale consists of ten dimensions of psychopathology established by factor analysis of interview ratings on newly admitted inpatients with a diagnosis of psychosis or severe neurosis. The dimensions, more fully described in the IMPS manual (5), are excitement (EXC), hostile belligerence (HOS), paranoid projection (PAR), grandiose expansiveness (GRN), perceptual distortions (PCP), anxious intropunitiveness (INP), retardation and apathy (RTD), disorientation (DIS), motor disturbances (MTR), and conceptual disorganization (CNP). In view of the satisfactory interrater reliability of most IMPS subscales (5), it seemed justifiable to use the ratings of only one rater (W.R.W.), who had had considerable experience in interviewing. To control for differences in sex on the IMPS, raw scores were converted to t scores (mean = 50, standard deviation = 10) by using normative data presented in the manual for acute male (N = 1,624) and female (N = 681) inpatients. These standardized scores were used in the analyses.

Admissions were also evaluated by residents, who made the diagnosis and recommendations for further inpatient or outpatient psychiatric treatment. They arrived at their decisions without reference to the information obtained by the interviewer. Patients given return appointments for outpatient treatment at Grady Memorial Hospital or at other psychiatric services in Atlanta were followed up to determine whether they kept their appointments at the designated facilities at any time (i.e., not necessarily the appointed time) within one month of their discharge from the unit.

RESULTS

An item analysis of the IMPS ratings (N = 75) revealed that only one of six items on the DIS subscale was endorsed, resulting in an internal reliability (coefficient alpha) of zero. The subscale was, therefore, omitted from analysis. Although the reliability for GRN was quite low (.34), it was not extreme enough to justify eliminating the subscale. The reliabilities for the remaining subscales varied from .61 to .87.

Psychopathology

The frequencies of the diagnoses were as follows: schizophrenia—58.7 percent (N = 44); neuroses—13.3 percent (N = 10); personality disorders—10.7 percent (N = 8); alcoholic psychosis and alcoholism—10.7 percent (N = 8); and nonalcohol-related organic brain syndromes—6.7 percent (N = 5). Because of the small number of patients, the nonschizophrenic groups were combined to obtain a larger number for purposes of statistical analyses, and comparisons were then made between schizophrenics and nonschizophrenics.

The frequency of a history of previous treatment was as follows: none—25.3 percent (N = 19); outpatient treatment—29.3 percent (N = 22); and inpatient treatment—45.3 percent (N = 34). Thus, 75 percent (N = 56) of the patients reported having had previous psychiatric treatment.

Differences between the mean IMPS t score of patients in this study and the mean t score of 50 (standard deviation = 10) for acute male and female inpatients in

TABLE 1.
Comparisons of Means on IMPS Subscales*

Scales	Whole Sample (N=75) Mean	z	Time of Admission: Day (N=36)	Night (N=39)	z	Disposition: In (N=24)	Out (N=43)	z	Return to Treatment: Yes (N=27)	No (N=16)	z
Excitement	44.5±6.5	4.7**	45.6±7.9	43.5±4.7	1.4	47.0±8.2	43.2±5.1	2.1***	43.1±5.5	43.3±4.3	0.1
Hostile belligerence	46.7±6.5	2.8**	47.4±7.0	46.1±6.0	0.9	48.9±7.7	45.9±5.9	1.6	45.5±5.3	46.5±6.7	0.5
Paranoid projection	45.8±8.4	3.6**	45.8±8.4	45.9±8.4	0.1	48.4±9.7	44.0±7.1	2.0***	45.1±7.5	42.0±6.0	1.5
Grandiose expansiveness	46.2±4.5	3.3**	46.2±4.4	46.2±4.7	0.1	47.5±6.5	45.0±1.4	1.9	45.1±1.6	44.6±1.0	1.4
Perceptual distortions	48.0±6.9	1.8	48.3±6.7	47.7±7.1	0.3	49.6±7.9	46.8±5.4	1.6	47.8±5.7	45.0±4.3	1.8
Anxious intropunitiveness	53.9±8.0	3.4**	53.8±8.5	54.0±7.7	0.1	54.7±9.7	52.9±7.3	0.8	52.2±7.5	54.1±6.8	0.9
Retardation and apathy	45.1±5.5	4.2**	45.0±5.7	45.2±5.2	0.2	46.0±6.0	44.9±5.4	0.7	45.8±5.5	43.4±4.7	1.5
Motor disturbances	44.4±6.2	4.8**	45.0±6.5	43.9±5.9	0.8	44.9±7.3	44.2±5.5	0.5	45.8±6.0	41.4±3.2	3.1**
Conceptual disorganization	48.4±6.9	1.4	48.9±6.8	48.0±7.1	0.6	50.7±6.8	46.9±6.3	2.3***	48.6±7.0	44.1±3.2	2.9**

*Mean ± standard deviation.
**$p < .01$.
***$p < .05$.

the normative sample were evaluated with the one-sample *z* test (see table 1). Patients in this study, as compared with those in the normative sample, scored significantly lower on excitement, hostility, paranoid projection, grandiosity, retardation and apathy, and motor disturbances; they did not differ on perceptual distortion and conceptual disorganization, and they scored higher on anxious intropunitiveness.

Time of Admission

The number of admissions divided almost evenly between day (N = 36) and night (N = 39). Of the day admissions, 64 percent (N = 23) were diagnosed as schizophrenic, and 54 percent (N = 21) of the night admissions had this diagnosis. There was no significant difference between these percentages ($\chi^2 = 0.43$). Day and night admissions did not differ on any IMPS subscales (table 1).

Disposition

Eleven percent (N = 8) were discharged without a recommendation for further inpatient or outpatient treatment; 32 percent (N = 24) were discharged to more extensive inpatient treatment, and 57 percent (N = 43) were given return appointments for outpatient treatment at either Grady Memorial Hospital or at other psychiatric services in the Atlanta vicinity.

The bivariate classification of patients according to history of psychiatric treatment and current disposition is shown in table 2. Slightly more than 50 percent of the patients in each category of the history variable received a current disposition of outpatient treatment. An insufficient number of patients in some categories precluded a chi-square analysis. There did not appear to be an association between previous treatment and current disposition.

Schizophrenia was diagnosed in 71 percent (N = 17) of 24 patients admitted to longer term inpatient treatment and in 51 percent (N = 22) of 43 patients with outpatient appointments. The difference between these percentages was not significant ($\chi^2 = 1.71$, df = 1, $p > .10$).

Significant differences were found on three IMPS subscales (see table 1). Patients with recommendations for inpatient treatment scored significantly higher on excitement, paranoid projection, and conceptual dis-

TABLE 2
Association of History of Psychiatric Treatment with Current Disposition

Disposition	History: None (N=19) Number	Percent	Outpatient (N=22) Number	Percent	Inpatient (N=34) Number	Percent	Total (N=75) Number	Percent
No treatment	2	10	4	18	2	6	8	11
Outpatient treatment	10	53	13	59	20	59	43	57
Inpatient treatment	7	37	5	23	12	35	24	32

TABLE 3
Association of History of Psychiatric Treatment with Return for Outpatient Appointment

Return	History							
	None (N = 10)		Outpatient (N = 13)		Inpatient (N = 20)		Total (N = 43)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Yes	4	40	7	54	16	80	27	63
No	6	60	6	46	4	20	16	37

organization than patients with outpatient appointments.

Return for Outpatient Appointment

Because the number of patients in these analyses was reduced to 43, it was felt that findings which were significant beyond the .10 level should be cited as suggestive of relationships that might reach the conventional level of significance ($p<.05$) with a somewhat larger sample. Of 43 patients with appointments for outpatient treatment, 63 percent (N = 27) returned for treatment within 30 days of their discharge from the observation unit.

The bivariate classification of patients according to history of treatment and return for treatment is shown in table 3. The group of patients with a history of inpatient treatment had the largest percentage of returnees (80 percent), while the group with no history of treatment had the smallest percentage (40 percent). About 50 percent of the patients with a history of outpatient treatment returned. There appeared to be a tendency for more patients to return if they had been previously hospitalized. An insufficient number of patients in certain categories prevented a chi-square analysis.

Sixty-three percent (N = 17) of 27 returnees, compared with 31 percent (N = 5) of 16 nonreturnees, were diagnosed as schizophrenic. These percentages differed beyond the .10 level of probability ($\chi^2 = 2.87$, df = 1), suggesting a tendency for schizophrenia to be associated with returning for an appointment.

The groups differed significantly on two IMPS subscales (see table 1), with returnees scoring higher on motor disturbances and conceptual disorganization than nonreturnees. The former group also tended to score higher on perceptual disorganization ($p<.10$).

DISCUSSION

More than 50 percent of the admissions were diagnosed as schizophrenic, while the others were almost evenly divided among neuroses, personality disorders, alcoholism, and organic brain syndromes. Compared to IMPS normative data on newly admitted inpatients with an acute psychotic or neurotic disorder, patients in this study were as deviant in conceptual disorganization and perceptual distortions and were more deviant in anxious intropunitiveness. The IMPS results are reasonably consistent with the psychological deviances, suggested by the frequent diagnosis of schizophrenia among these patients.

Almost one-half of the sample had previously been hospitalized for emotional problems, while the remaining half was nearly equally divided among outpatient treatment and no previous treatment. These findings on the patients' history of treatment and on the nature of their psychopathology are indicative of quite serious and persistent psychological problems in a large proportion of the sample.

No difference was found in the number of patients admitted during the day (6:00 a.m. to 5:59 p.m.) as compared with during the night (6:00 p.m. to 5:49 a.m.). The time of admission was unrelated to psychopathology, as assessed by diagnosis and IMPS ratings. These findings provide evidence of a need for a brief hospitalization unit to be adequately staffed to accept admissions and to provide treatment on a 24-hour basis.

Almost twice as many patients were discharged with outpatient appointments than to inpatient treatment facilities. The percentage of outpatient dispositions did not vary according to whether patients had a history of inpatient, outpatient, or no treatment for emotional problems. This finding implied that a sizeable number of seriously disturbed persons, as judged by a history of inpatient treatment, were to be treated in the community rather than in a hospital. Consistent with this implication was the finding that the percentages of schizophrenics in the outpatient and inpatient disposition groups were essentially the same.

What psychological characteristics of patients, if any, were associated with recommendations for inpatient and outpatient treatment? Evidence pertinent to this question comes from differences found in the IMPS ratings. Compared with outpatients, inpatients were more hyperactive and emotionally overactive, more suspicious and distrusting of people, and more disorganized in thought processes. It may be that this set of characteristics is associated with particularly ineffective adjustment in many aspects of daily life and necessitates placement in the more structured and protective setting of a hospital. Moreover, patients with this type of psychopathology may be exceptionally difficult to manage on a brief hospitalization unit that has a relatively unstructured program. Direct admission of these patients to an inpatient service may be more beneficial to them and may result in a more effective utilization of the brief hospitalization unit for other patients.

Slightly more than one-half of the patients who were discharged with outpatient appointments returned for treatment within 30 days of their discharge. Trends in the data suggested that more patients returned if they had a history of inpatient treatment and if they were diagnosed as schizophrenic. Compared with nonreturnees, returnees were more deviant at the time of admission on the IMPS subscales of motor disturbance and conceptual disorganization and tended to be more deviant on perceptual distortion.

These several findings consistently suggested that returnees had, at the time of admission, more persistent and incapacitating psychological problems than nonreturnees. Because this study did not reevaluate returnees and nonreturnees during the follow-up period, it cannot be concluded that the returnees had greater psychopathology at follow-up. It is possible that other factors were associated with both the extent of pathology at the time of admission and with keeping return appointments. For example, the staff may have communicated a somewhat more persuasive message about returning for further treatment to the more disturbed patients; consequently, these patients may have been more inclined to keep their appointments even though their problems had improved to some degree.

Another question raised by the findings on return appointments is whether some of the appointments were actually necessary. Nonreturnees, rated significantly lower on certain IMPS subscales, may not have been as incapacitated in their daily lives as the treatment staff believed. For these patients strong encouragement to seek further treatment when they feel it is needed may have been more appropriate than setting an exact time to return. More research is needed to help specify under what circumstances return appointments are warranted; otherwise, return appointments may be given indiscriminately.

REFERENCES

1. Jacobson GF, Wilner DM, Morley WE, et al: The scope and practice of an early-access brief-treatment psychiatric center. Am J Psychiatry 121:1176–1182, 1965
2. Beahan LT: Emergency mental health services in a general hospital. Hosp Community Psychiatry 21:81–84, 1970
3. Weisman G, Feirstein A, Thomas C: Three-day hospitalization—a model for intensive intervention. Arch Gen Psychiatry 21:620–629, 1969
4. Rhine MW, Mayerson P: Crisis hospitalization within a psychiatric emergency service. Am J Psychiatry 127:1386–1391, 1971
5. Lorr M, Klett CJ: Inpatient Multi-Dimensional Psychiatric Scale. Palo Alto, Calif, Consulting Psychologists Press, 1967

Utilization Review of Psychiatric Inpatient Care

BY ALEX RICHMAN, M.D., AND HENRY PINSKER, M.D.

The authors describe a utilization review procedure for inpatient care involving the statement of therapeutic goals, predictions about the time required to reach these goals, and the evaluation of care in terms of whether the goals have been met. The effectiveness of the procedure is suggested by the decrease in the number of patients with prolonged stays and the increase in the number of patients cared for. This has been accomplished with no decline in the quality of service.

SCRUTINY OF THE QUALITY of care given to patients has always been an important concern to physicians, especially those in supervisory positions who are required to evaluate the quality of care provided by their subordinates. But the manner in which this supervision has been conducted is left to the discretion of the physicians involved. The legislation that established Medicare set forth the requirement that each hospital develop a systematic procedure for evaluating the quality of medical care "on the basis of documented evidence to support the diagnosis, treatment, and to justify utilization of hospital facilities."

Each hospital is free to establish its own procedures. Most frequently a utilization review committee is charged with responsibility for evaluating the appropri-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the Department of Psychiatry, Beth Israel Medical Center, 307 Second Ave., New York, N.Y. 10003, where Dr. Richman is Associate Director for Utilization and Review Activities and Dr. Pinsker is Chief of the Inpatient Service. In addition, Dr. Richman is Professor and Dr. Pinsker is Associate Clinical Professor of Psychiatry at the Mount Sinai School of Medicine, City University of New York.

The authors wish to acknowledge the assistance of Ms. J. Riegel and Ms. T. Dubrow.

ateness of admission, diagnostic evaluation, treatment plan, type and quality of treatment rendered, length of stay, use of ancillary services, and posthospital plan.

Published works on utilization do not provide distinctive approaches for psychiatric services. The American Psychiatric Association monograph *Psychiatric Utilization Review* (1) describes review practices that are more appropriate for patients with medical or surgical conditions than those with psychiatric ones; each of the four models presented focuses on promptness and efficiency as the criteria to be examined. The Psychiatric Utilization Review and Evaluation Project at Yale (2), sponsored by the National Institute of Mental Health, has developed an evaluation procedure that is very specific in providing criteria for evaluating the quality of the written records of psychiatric patients. Its approach to utilization review, also following the medical-surgical model, selects for critical review charts of patients whose stay has deviated from norms developed for the hospital. The recently published American Medical Association manual on peer review (3) ignores the problems of psychiatric services.

A new statement from the Joint Commission on Accreditation of Hospitals (4) makes clear that evaluation of medical care encompasses both utilization review and quality of medical care. While the content of the medical record is indispensable in evaluating care, records of high quality are not an end in themselves. Ultimately, assessment of the quality of medical care must consider success in producing the desired result, the timeliness or promptness in delivering definitive care, the appropriateness of the length of hospital stay, the accessibility of treatment, and the acceptability of the care to the patient.

BACKGROUND

In this paper we shall describe the utilization review procedure employed on the inpatient service of the department of psychiatry of Beth Israel Medical Center, New York City. Our utilization review committee directs its attention primarily toward patients still hospitalized rather than to the records of patients who have already been discharged. The responsibility for developing utilization review procedures has been decentralized to individual departments, and a statistical summary of the departments' reviews are provided to the central utilization review committee. Within the department of psychiatry, subcommittees have been established for each of the inpatient services. The three-member subcommittee for the 36-bed general psychiatric inpatient service includes the departmental representative to the medical center committee and the chief of the inpatient service.

PROCEDURE FOR CONSIDERING EXTENDED STAYS

The utilization review procedure we have evolved considers the appropriateness of admissions, the need for emergency admissions, underutilization, and extended stay. This paper describes only the methods for monitoring extended stay.

In general hospitals the average duration of stay for patients on psychiatric services is short. For the estimated 305,000 discharges from nongovernmental general hospital psychiatric inpatient units for the period September 1970 to August 1971 there was a median stay of 13.6 days (5).

New York State and New York City regulations restrict Medicaid payment for psychiatric hospitalization to 30 days; reimbursement for 30 additional days is permitted if the request for the extension is approved by a hospital utilization review committee. Since the majority of our patients are subject to Medicaid requirements, we have defined "extended stay" as over 30 days for all patients.

On the 20th hospital day, a review form is sent to each psychiatrist, to be completed before the 23rd day. Since the psychiatrist is requesting authorization for a longer stay, he must explain why discharge cannot be accomplished by the end of 30 days and he must justify his expectation that improvement will occur within the next 30 days. Most items on the one-page form are self-explaining (appendix 1).

In psychiatry more often than in general medicine and surgery, it is policy rather than clinical necessity that determines which admissions are considered appropriate and what type of treatment will be provided (6). The utilization review committee, if it is to avoid usurping the policy-making role, must limit its inquiry to the clinician's success in carrying out the policy. In our service, policy dictates that any patient thought to need admission is admitted with the understanding that psychiatric hospitalization is intended to achieve many complex objectives. Treatment goals may include improvement of symptoms, evaluation of current social and therapeutic options, and preparation of a sound plan for continuing care after discharge. Personality change and rehabilitation are not expected, but patients are involved in an extensive program of therapeutic activities while they are hospitalized.

Psychiatric diagnosis is not requested on the form. It may be possible in general medicine and surgery to establish norms for duration of stay for different diagnostic entities or procedures, but it has been clearly demonstrated that none of the schizophrenic entities preserved in our diagnostic system has prognostic value. Since most of our patients are diagnosed as suffering from some form of schizophrenia or affective disorder, diagnosis alone does not determine the treatment or suggest the appropriate length of stay as much as for medical services. Far more useful in psychiatry is the chief complaint or the reason for hospitalization. It is rare indeed for a patient whose admission is occasioned by an overdose of sleeping pills to remain for a month. An acute psychotic episode, whether a first one or a recurrence, will usually subside in two to four weeks, but progressive disorganization of behavior is associated with longer periods of treatment.

Very little space is made available on the utilization review form for the patient's history, and only recent history is requested. Data about childhood and adolescence,

although fascinating to most psychiatrists and useful in psychotherapy, do not provide information appropriate to a utilization review committee. A history of many short hospitalizations suggests that short hospitalization will be effective; a history of a prolonged hospitalization suggests the opposite. A history of recent depression is compatible with a short stay, but a history of recurrent severe depressions gives the review committee reason to expect that a longer stay and electrotherapy may be appropriate.

Perhaps the most useful feature of the utilization review form is the space in which the treating psychiatrist is required to indicate his therapeutic goals in behavioral terms. Examples of such goals include remission of symptoms, stabilization of medication, or development of an aftercare plan in which the patient will cooperate. One of the principal causes of prolonged hospital stay is vagueness about the therapeutic goal. It is easy to allow another week to pass, and then another, as a psychiatric resident explores the patient's ability to relate to him or seeks to understand the relationships within the patient's family. Important though these concerns are, they do not meet the essential requirement of a goal—that *it be recognizable when reached.*

The reasons for a psychiatric patient's not being ready for discharge within the arbitrarily selected period of 30 days are limited to the categories of: a) delay in completing diagnostic studies, b) delay in completing discharge plans, and c) failure of the patient to improve.

The items on the review form include some that reveal deficiencies in staff performance, an indication that corrective action is needed, and some inevitably related to the patient's condition. The psychiatrist is asked for concise explanations to accompany the checked items. It is not sufficient to state that the patient is improving with psychotherapy; it is expected that an explanation be provided about why, if 30 days have not been enough, there is reason to believe that another few weeks will be.

When the review form has been completed by the treating psychiatrist, it is first reviewed by the chief of the inpatient service, a member of the subcommittee. He adds explanations of unclear items or indicates to the treating psychiatrist the need for clarification. If he recommends further hospitalization, the other two members of the subcommittee review the information weekly. If a patient remains in the hospital, the form must be resubmitted on the 53rd day and weekly thereafter.

RESULTS

The form has been revised a number of times so that it now covers the range of situations appropriate to our setting. Completion of the form by the psychiatrists has become sufficiently satisfactory that it is rarely necessary to seek additional information from the chart or the attending psychiatrist.

Early versions of the form provided space for the psychiatrist to indicate the treatment method proving beneficial to his patient. This was eliminated when it was found that "psychotherapy" and "milieu therapy" had been checked for almost all patients. Only the supervising psychiatrists were willing to face the possibility that for certain patients, psychotherapy was not the most significant treatment.

In the same way one must be able to recognize when treatment goals have been reached, one must be concerned whether the goals of the utilization review procedure itself have been attained. In March 1972 we were able to consider the initial effect of the utilization review procedure upon duration of stay and patient movement within the psychiatric inpatient service. At that time we compared the 11-month periods before and after the initiation of our utilization review procedure. The following facts emerged:

1. The mean stay for all discharges decreased one-fifth, from 26 days to 21 days.
2. The mean stay of short-stay patients (under 31 days) remained constant (14 days), while the number of short-stay patients increased from 176 to 275.
3. The mean stay of long-stay patients (31 or more days) decreased from 50 to 45 days, while the number of long-stay admissions decreased from 92 to 83.
4. The number of admissions increased from 268 to 358, and the proportion of admissions becoming long-stay patients decreased from 34 to 23 percent.

CONCLUSIONS

Utilization review of psychiatric inpatient care cannot be based on diagnosis or type of treatment as precisely as in medicine or surgery because psychiatric treatment approaches tend to be determined by theoretical positions, for which there are usually few data to justify one approach over another. Although goals of hospitalization and the time required to attain them vary from hospital to hospital, the definition of goals for a specific service setting is possible. It has been feasible to develop a systematic procedure for stating attainable therapeutic goals, to make useful predictions about the time required to attain them, and to evaluate care in terms of whether they have been met.

This utilization review procedure requires that during the course of hospitalization the treating psychiatrist present concise data on a one-page form regarding the achievement of the objectives. This procedure is more efficient than the detailed perusal of notes on the day-to-day course of hospital care. The effectiveness of this procedure is evident in that the number of patients with prolonged stays has been reduced and more patients have been cared for. This has been accomplished without reducing the quality of service or increasing the available resources.

Review of utilization is not the same as audit of the quality of care. Utilization review is intended to reveal whether the hospital policy is being carried out with regard to efficient use of facilities and the patient's time. Review of the quality of care has more to do with the excellence or proficiency of the physician. Efficiency and

proficiency are not incompatible qualities, but one should always be clear about which one is being discussed.

When the focus of review activity is upon thoroughness of records, emphasis is subtly placed on the chart and on the individual physician's scholarship or meticulousness. The procedure described here directs attention to the needs of the patient. It appears that many psychiatrists, if asked what they are doing, are able to proceed quickly and, as far as we have been able to determine, without harm to the patients.

REFERENCES

1. American Psychiatric Association: Psychiatric Utilization Review: Principles and Objectives. Washington, DC, APA, 1968
2. Riedel D, Brenner MH, Brauer L, et al: Psychiatric utilization review as patient care evaluation. Am J Public Health 62:1222–1228, 1972
3. American Medical Association: Peer Review Manual. Chicago, AMA, 1971
4. Policy Statement on Medical Care Evaluation and Utilization Review. Approved by the Board of Commissioners of the Joint Commission on Accreditation of Hospitals, Chicago, August 11–15, 1971
5. National Institute of Mental Health, Biometry Branch, Survey and Reports Section: Length of Stay for Discharges from General Hospital Psychiatric Inpatient Units, United States 1970–1971, Statistical Note 70. Washington, DC, US Government Printing Office, 1969
6. Pinsker H, Robbins E, Kleinerman G: Psychiatric hospitalization: role of administration policy. NY State J Med 72:1764–1768, 1972

APPENDIX 1

Certification of Need for Continued Stay: Beth Israel Medical Center-M.J. Bernstein Institute Psychiatric Inpatient Service, Utilization Review

Dr. _____, on _____, your patient _____ will have been hospitalized 23 days. If you anticipate that more than 30 days of inpatient care is needed, please complete and return this form before the 23rd day. If discharge is anticipated before 30 days, check here ☐ and return.

1. What symptoms or behavior necessitated current admission?

2. Has patient been hospitalized before?
   ☐ No ☐ Yes: _____ times, last hospitalization at _____, usual length of stay _____.

3. Therapeutic goals for this admission:
   ☐ a. remission of symptoms
   ☐ b. evaluation of previous psychotherapy
   ☐ c. planning for psychotherapy
   ☐ d. planning for other care
   ☐ e. diagnostic evaluation
   ☐ f. other
   Elaborate briefly, making clear what is to be accomplished or what problems exist.

4. ☐ Discharge not possible because necessary work-up not completed early enough; explain.

5. Discharge not possible because discharge plans not complete:
   ☐ a. planning not initiated promptly
   ☐ b. direction of planning had to be altered during hospitalization
   ☐ c. discharge difficulties related to:
      ☐ 1) patient's motivation or acceptance of situation
      ☐ 2) insufficiency of community resources
   ☐ d. physical illness of patient prevents completion of plans
   ☐ e. transfer pending
   Give specific details to illustrate the problem.

6. ☐ There was a relapse, but patient is now improving; describe.

7. ☐ Type of therapy was changed during hospitalization; specify.

8. ☐ Discharge within _____ days from now is anticipated.

9. Explain reasons for requesting further hospitalization beyond 30 days.

_____ _____
Date Physician

Action: ☐ Approved ☐ Disapproved ☐ More information needed

Relationships Between Length of Stay in and out of the New York State Mental Hospitals

BY ABBOTT S. WEINSTEIN, M.A., DIANE DIPASQUALE, M.S., AND FREDERICK WINSOR

Most of the patients who left the New York State hospitals during the past six years remained out for substantial periods of time. The length of time out of the hospitals was related to the length of stay in the hospitals only to a minor degree, but the length of time out was strongly related to the number of previous hospitalizations. Patients aged 16 to 64 years left much sooner and returned slightly sooner than the younger or older patients. Inpatient stays were shortened markedly from 1966 to 1971. The length of time out of the hospitals after inpatient stays also tended to decrease, but to a far lesser extent; 1971 showed an exception to the trend.

SINCE 1955, when the peak census of the New York State mental hospitals exceeded 93,000 patients, the patient population has decreased to less than half of that number; it is now going down more rapidly than ever before. The drop in the state hospital census is especially remarkable since, for most of the period since 1955, it was accompanied by a substantial increase in admissions. More inpatients were being served, but for generally shorter periods of time. For patients admitted in 1954, the median length of stay was eight months. For those admitted in fiscal year 1971, the median stay was approximately one and a half months.

The more rapid release[1] of newly admitted patients resulted in smaller numbers of patients being added to the so-called "chronic" group—defined arbitrarily as those hospitalized for two years or longer (1). At the same time, however, the more rapid releases were followed by increases in the number of readmissions, leading some observers to conclude that the faster releases were making the state hospitals something akin to revolving doors.

The authors are all with the New York State Department of Mental Hygiene, 44 Holland Ave., Albany, N.Y. 12208, where Mr. Weinstein is Director of Statistics and Clinical Information, Ms. DiPasquale is Associate Programmer, and Mr. Winsor is Chief of Statistical Operations. Ms. DiPasquale is also Chairman of the Mathematics Department, College of St. Rose, Albany, N.Y.

This work was supported in part by Public Health Service grant MH-14934 from the National Institute of Mental Health.

[1] The word "release" has been used generally in the mental health field as indicating a significant removal from inpatient status. Some objections to the use of this term have been made on the grounds that it implies the termination of an involuntary incarceration. Such a connotation of the term as used here is inaccurate and should not be inferred.

It is, of course, possible that the reduction in "chronicity" could be a statistical illusion, based on brief and artificial interruptions of essentially continuous periods of illness. Alternatively, it might be shown that the preponderance of those released remain out of the hospital for substantial periods of time.

This report is designed to show: 1) how long individuals who leave state hospital inpatient care remain out of the hospital, 2) how their length of stay out of the hospital is related to their length of stay in the hospital, and 3) how these patterns have changed during the past six years.

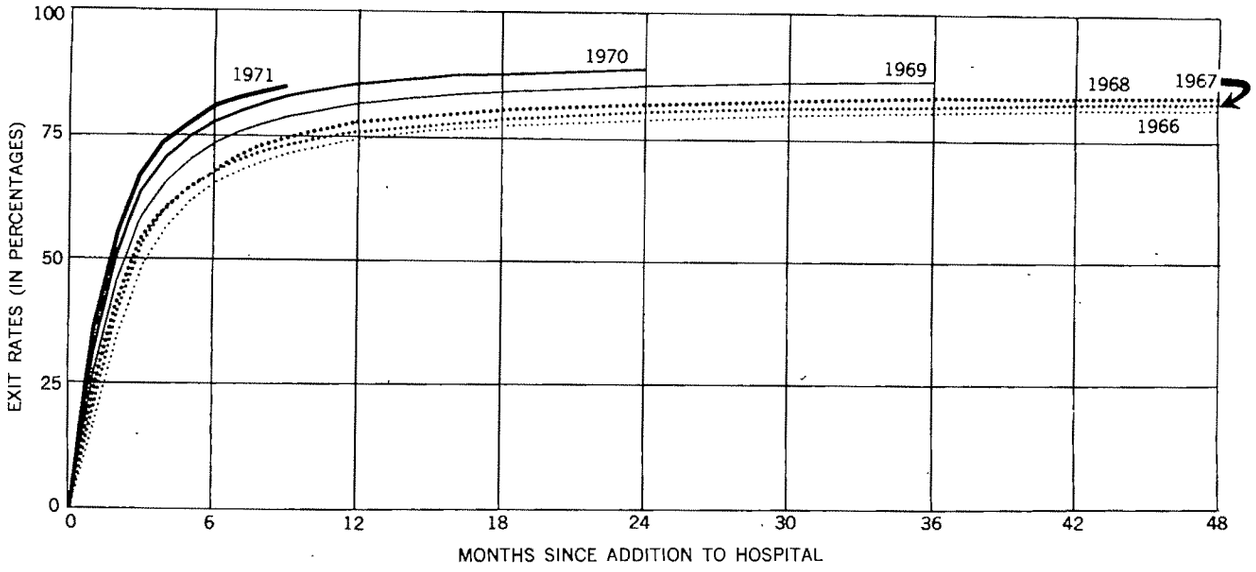
LENGTH OF STAY IN AND OUT OF THE HOSPITAL

Figure 1 shows the proportions of each year's hospital additions (admissions plus returns from convalescent care) who leave the hospital within one month, two months, and so forth after their entry into the hospital. Of the additions during the 1971 fiscal year (the year ended March 31, 1971), 35.3 percent left the hospital alive within one month, 55.9 percent within two months, and so forth, with a total of 85.1 percent leaving alive within nine months. For convenience, the percentages of patients leaving within a given length of time will be called "exit rates."

In figure 1 two major patterns stand out. First, a continuing increase in the exit rate from 1966 to 1971 is shown. This is indicated by the fact that the curve for each succeeding year lies above the curve for the previous year. Second, in spite of this marked increase from year to year, the shape of all the curves is quite similar. The first three months after entry into the hospital are by far the most active in terms of exits; more than half of all individuals added had left the hospital within that length of time (except for 1966, when the proportion was not quite 50 percent). From three to roughly nine months after hospital entry, the overall exit rate rises more slowly, and after about nine months the additional proportion leaving is relatively small. For example, for the group who entered in 1968 it required only three months for 54 percent to leave, another six months for the next 21 percent to leave, and 39 months for the next nine percent of the original group to leave the hospital. (The data supporting all figures in this report are available on request, along with comparable tables and charts by age groups.)

Figure 2 shows the proportion of patients released (direct discharges plus placements on convalescent care)

FIGURE 1
Percentage of Patients Released Alive Within Specified Length of Time Since Addition: Years Ended March 31, 1966–1971



who return to the hospital within one month, two months, and so forth after release. Of those released during the 1971 fiscal year, 11.0 percent returned within one month, 15.8 percent within two months, and 32.8 percent within nine months of their release. The percentages returning within a given length of time will be called "reentry rates."

The overall patterns shown in figure 2 differ from those in figure 1 most noticeably in that the percentages in figure 2 are much lower at any point. For example, referring to 1971 in each case, figure 1 shows that within six months after hospital entry, about 80 percent had left the hospital alive; figure 2 shows that within six months after leaving the hospital, about 28 percent had returned.

Aside from the considerably lower percentages, the patterns in figure 2 are roughly similar to those in figure 1 in that: 1) the percentages have tended to increase over the six-year period (in figure 2, 1971 is a noticeable ex-

FIGURE 2
Percentage of Patients Returned Within Specified Length of Time Since Release from Hospital: Years Ended March 31, 1966–1971

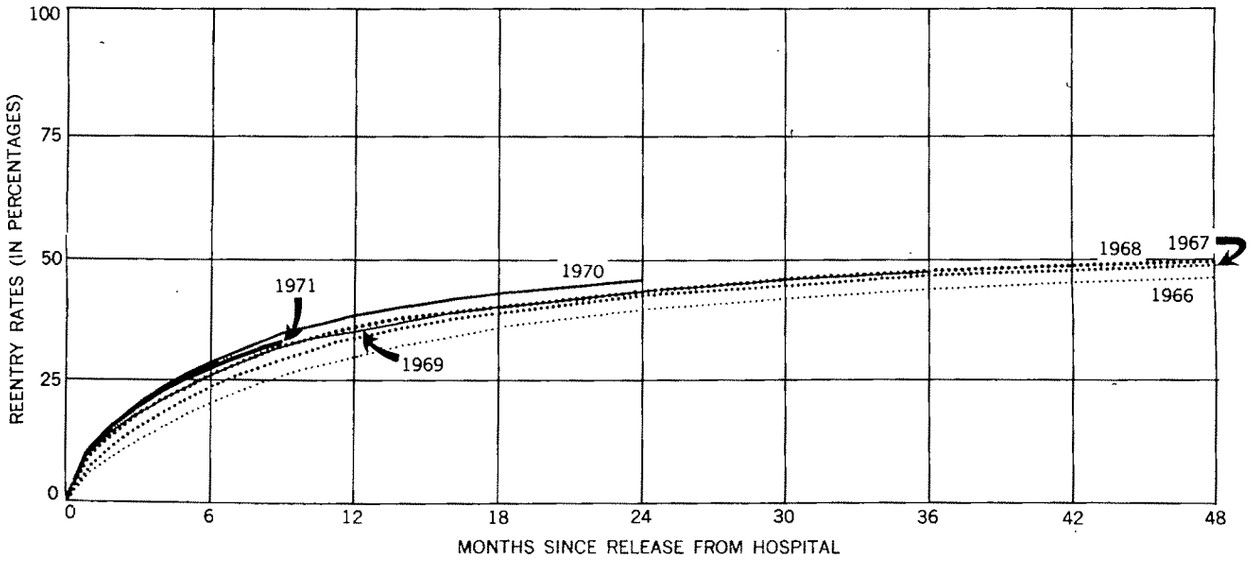


TABLE 1
Length of Stay in New York State Hospitals and Children's Hospitals by Selected Patient Characteristics: Fiscal Year Ended March 31, 1971

Characteristic	Additions*				Releases**		
	Number	Percent	Median Hospital Stay (in days)	Exit Rate	Number	Percent	Reentry Rate
Age							
Less than 16	1,328	3.2	183	22.1	1,217	2.9	20.4
16–20	3,144	7.6	48	57.9	3,276	7.7	24.0
21–64	32,887	79.2	45	61.4	34,891	82.5	28.7
65 and over	4,172	10.0	over 270	22.2	2,924	6.9	22.4
Total	41,531		51	55.9	42,308		27.7
Diagnosis							
Psychosis of old age	2,322	5.6	over 270	12.7	1,108	2.6	22.1
Organic brain syndrome***	1,216	2.9	110	36.9	1,088	2.6	29.6
Mental retardation	530	1.3	94	41.1	645	1.5	35.2
Schizophrenia	16,848	40.6	60	50.2	18,536	43.8	30.9
Affective disorders	1,682	4.0	52	56.4	1,790	4.2	27.9
Other psychoses***	816	2.0	48	59.2	845	2.0	19.1
Other*** and undiagnosed	6,183	14.9	42	61.8	5,989	14.2	19.2
Personality and behavior disorders	1,584	3.8	38	63.8	1,804	4.3	23.7
Alcohol-related conditions	7,054	17.0	30	71.5	7,103	16.8	31.5
Drug-related conditions	1,013	2.4	31	73.9	1,086	2.6	18.9
Psychoneuroses	2,283	5.5	27	77.0	2,314	5.5	21.6
Legal status†							
Involuntary	18,112	43.6	68	46.5	10,357	24.5	25.3
Voluntary	19,286	46.4	41	62.7	27,952	66.1	29.8
Criminal procedure	918	2.2	49	55.6	578	1.4	29.6
Alcohol status	2,302	5.6	40	70.7	2,351	5.6	22.9
Narcotic status	890	2.1	30	63.0	893	2.1	4.6
Other	23	0.1	25	78.3	177	0.4	4.0
Previous stays							
None	19,387	46.7	52	55.3	18,804	44.4	16.3
1	7,963	19.2	53	54.8	8,320	19.7	26.3
2	4,951	11.9	54	54.0	5,200	12.3	32.2
3	3,138	7.6	54	54.5	3,423	8.1	38.2
4	2,031	4.9	51	56.4	2,205	5.2	41.5
5	1,282	3.1	48	58.6	1,413	3.3	50.3
6	870	2.0	43	62.1	933	2.2	55.0
7	553	1.3	43	62.7	583	1.4	56.4
8 and over	1,356	3.3	31	72.4	1,427	3.4	69.7

*Additions are admissions plus returns from convalescent care; median stay shown here is based on time until release alive.
**Releases are direct discharges plus placements in convalescent care.
***Not elsewhere classified.
†The "involuntary" and "voluntary" groups exclude involuntary and voluntary patients who are included in the other groups shown.

ception), and 2) the percentages rise more rapidly in the early months and more slowly as time passes.

On the basis of figure 2, it is clear that the preponderance of individuals who leave inpatient status remain out of the hospital for substantial periods of time. Approximately three out of every four remain out of the hospital for at least six months, while half of the original group remain out for at least four years.

EFFECT OF VARIOUS PATIENT CHARACTERISTICS ON STAY

Just as there is no unitary condition of "mental illness," there is no single, normative length of stay that would apply to all mental hospital patients. Length of stay in and out of the hospital is compared in table 1 for age, diagnosis, and legal status groupings, as well as for the number of previous hospitalizations.[2]

In order to simplify the presentation, length of stay in the hospital is measured in terms of the percentage of additions who are released alive *within two months*. Similarly, length of stay out of the hospital is measured in terms of the percentage of releases who return *within six*

[2] Additional tables and graphs are available on request from Mr. Weinstein.

months. Use of such summary measures is particularly appropriate in view of the remarkable consistency of the more detailed overall patterns, such as those shown in figures 1 and 2.

Age Group Differences

The age groups shown here are those used by the New York State Department of Mental Hygiene for program planning and general operations. Table 1 shows that, of those who entered the hospital in the 1971 fiscal year, the proportion who left within two months (the exit rate) was highest for the large group aged 21 to 64 (61.4 percent), followed closely by the group aged 16 to 20 (57.9 percent). The rates for the youngest and oldest age groups were very much lower and nearly identical (about 22 percent).[3] The proportion who returned within six months (the reentry rate) varied much less among the four age groups than did the exit rate, but the ranking of the four groups was the same for both measures.

Attention is directed to the smaller reentry rate for patients aged 65 and over than for those aged 21 to 64 (22.4 percent compared with 28.7 percent). The lower rate for the older patients is probably explained in part by the fact that many in this group are placed in alternative residential facilities, such as nursing homes. In addition, some who could otherwise require rehospitalization might die in the interim.

Diagnosis Group Differences

In table 1 the diagnostic groups are arranged in order of the exit rate. The rates show a very wide range, with a 12.7 percent exit rate for patients with psychoses of old age, 50.2 percent for the large schizophrenic group, and 77.0 percent for those with psychoneuroses.

Of those who left the hospital, the highest reentry rates were found for the mentally retarded [4] (35.2 percent), those with alcohol-related conditions (31.5 percent), and those with schizophrenia (30.9 percent). The lowest reentry rates were found for those with "other psychoses" (19.1 percent) and psychoneuroses (21.6 percent). Only 18.9 percent of those with drug-related conditions returned within six months, but most of the individuals treated in residential facilities primarily for drug-related conditions are served by facilities operated by the State Narcotics Addiction Control Commission, which are not covered in this report. Moreover, the bulk of the Department of Mental Hygiene narcotics program was terminated by May 1971.

Unlike the situation with the four major age groups, the patterns by diagnostic group summarized in table 1 show no apparent association between the length of stay in and out of the hospital.

[3] Of the oldest group, an additional 13 percent died within two months of hospital entry, bringing the total separations within two months for that age group to 35 percent.

[4] Includes only the mentally retarded who were served in the state hospitals and children's hospitals and who ordinarily had secondary psychiatric diagnoses. The mentally retarded served in the state schools for the mentally retarded are not covered in this report.

Legal Status Differences

Patients admitted voluntarily left the hospital earlier than those admitted involuntarily and tended to return a little sooner, as shown in table 1. However, patients admitted under alcoholic legal statuses left the hospital sooner than those in the other categories and remained away from the hospital longer. The stay patterns for those admitted under the Criminal Procedure Law are affected strongly by administrative and legal considerations that may not be related directly to the patient's mental condition. The very low reentry rate for patients with narcotics legal statuses reflects the situation noted above with respect to drug-related diagnoses.

The large "involuntary" and "voluntary" groups exclude involuntary and voluntary patients who were shown in other categories. Nearly all of the alcohol group were voluntary, while the criminal procedure groups and three-fourths of the narcotics group were involuntary.

Parenthetically, table 1 shows that the proportions who were "voluntary" and "involuntary" at the time of hospital entry were fairly close—46.4 and 43.6 percent, respectively. By the time the patients left the hospital, however, those who were "voluntary" outnumbered the "involuntary" by 66.1 percent to 24.5 percent. This occurred because many patients admitted involuntarily agree to remain voluntarily once treatment has begun.

Number of Previous Stays

Table 1 shows a strong relationship between the number of previous stays and the length of time *out* of the hospital. For patients with no previous stays, only 16.3 percent returned within six months; for those with one previous stay, the comparable rate was 26.3 percent, and the rate increased with each additional number of previous stays, reaching 69.7 percent for those with eight or more.

In contrast, there was essentially no change in the length of time *in* the hospital prior to release until the patients had four or five previous stays. The fact that there was no change in the exit rate for the first several stays is particularly notable: 85.4 percent of all hospital additions had fewer than four previous stays.

Indirect Versus Direct Comparisons

In the preceding sections, the exit rates and reentry rates were reviewed in parallel for several patient characteristics. It is clear that, although there is a substantial overlap, the individuals released during a given year are not necessarily the same individuals who were added during that year. However, there are practical problems in comparing the length of stay in and out of the hospital for the same individuals. An analysis of this type requires a period of time over which the individuals studied can be followed. In order to reflect the most recent experience for both additions and releases, additions were followed as one set of cohorts and releases as a separate set. We believe that this compromise does not seriously affect the present findings, but the issue is being pursued in ongoing analysis.

TABLE 2
Reentry Rates (Percent of Releases Returned Within Six Months) by Length of Hospital Stay Before Release, New York State Hospitals and Children's Hospitals: Year Ended March 31, 1971*

Length of Stay Before Release	Number	Percent	Reentry Rate Within Six Months
Less than 3 months	27,925	66.0	27.9
3–5 months	5,522	13.1	27.6
6–11 months	3,257	7.7	29.1
1–2 years	1,805	4.3	29.8
2–5 years	1,476	3.5	26.2
5 years or more	2,323	5.5	21.9
Total	42,308		27.7

*Direct discharges plus placements on convalescent care.

REENTRY RATES BY TIME IN HOSPITAL PRIOR TO RELEASE

In table 2 the reentry rates are related *directly* to the length of time in the hospital before release. At best, there was very little association between the length of hospitalization and the reentry rate. The modest association that could be inferred would indicate a slightly more rapid return for those released between six months and two years after hospital entry than for those released either earlier than six months or later than two years. If there were in fact a kind of "revolving door" system, one might have expected those released earliest to return earliest. At the same time, one might have expected that those who were released later would have been the sicker patients, who would be more likely to return sooner (2). This issue could be examined directly if an adequate measure of severity of disability were available. Lacking such a measure, the reentry rates by time prior to release will be controlled for diagnosis and other characteristics that may be related to degree of disability. This analysis is in progress.

INTERHOSPITAL AND INTERCOUNTY DIFFERENCES

The exit rate and reentry rate for the 26 state hospitals that operated during fiscal 1971 were compared. The exit rates ranged from a low of 32.4 percent to a high of 91.2 percent, while the reentry rates ranged far more narrowly but still substantially, from 19.5 percent to 37.2 percent. The interhospital differences in exit and reentry rates cannot be explained by differing age compositions in the various hospitals; wide differences in the rates from hospital to hospital were found for each of the age groups.

In spite of some association between high exit and reentry rates at three of the hospitals, there was no discernible association for the other 23 hospitals. The rank correlation coefficient (Spearman) for the 26 hospitals was +.47, greater than would be expected due to chance alone. However, a review of the scatter chart (not shown here) shows these three hospitals to be atypical. If these are excluded, the rank correlation for the remaining 23 hospitals is +.23.

The primary focus of present mental health planning and operation of services is on the local area of residence of those who might be served. Exit and reentry rates were compared for the 62 counties in the state. The exit rates varied from 32.6 percent for Herkimer County residents to 76.0 percent for Lewis County. The reentry rates ranged from zero for Hamilton County to 35.7 percent for Suffolk County. Comparing New York City and the rest of the state, the exit rates were 50.2 and 61.1 percent, and the reentry rates were 27.0 and 28.6 percent, respectively.

Overall, there was very little relationship between the exit and reentry rates by county of residence. The rank correlation coefficient was +.32, greater than would be expected due to chance alone. However, to put this in perspective, this level of correlation means that only ten percent of the variation in the reentry rates is associated with the variation in the exit rates (based on the ranking).

SIX-YEAR TRENDS

The six-year trends noted above with reference to figures 1 and 2 were analyzed in more detail by focusing on the exit rates within two months and the reentry rates within six months. For all ages combined, there was a very pronounced upward movement in the exit rate, from 34.0 percent in fiscal year 1966 to 55.9 percent in 1971. The trend in the reentry rate also increased during the six-year period, but the rise was far less pronounced and less consistent. From 20.4 percent in 1966, the reentry rate rose to 28.5 percent in 1970 and dropped slightly to 27.7 percent in 1971.

Among the four major age groups, the overall trends for the large 21- to 64-year-old group (79.2 percent of the total in fiscal 1971) and the 16- to 20-year-old group were more nearly similar to one another than to either the youngest or the oldest group. For the reentry rates, although the levels for all four age groups were of roughly the same order of magnitude, the trends for the two central groups were generally upward except in 1971, while the trends for the youngest and oldest groups have tended to decline since 1968.

FURTHER ANALYSIS

Each of the comparisons covered in this report requires further analysis. It is conceivable that the coarseness of the groupings could have masked meaningful relationships. Moreover, certain categories of patients are of special interest to particular groups. More detailed analysis is under way to cover: 1) six-year trends, 2) additional variables such as sex and ethnic group, 3) mental health center catchment areas, 4) the elderly, 5) children and adolescents, 6) hospital units, 7) schizophrenics, 8) alcoholics, 9) more detailed age groups, 10) detailed diag-

noses, 11) detailed legal statuses, 12) comparisons with private hospitals, 13) family care stay patterns, 14) the direct relationship between reentry rates and exit rates for the same groups of individuals, 15) alternative definitions and methods of studying length of stay in and out of hospitals, 16) use of exit and reentry rates in operating services and monitoring systems of service, and 17) seasonality.

ACKNOWLEDGMENTS

The authors wish to acknowledge the contribution of many individuals who have regularly, over a period of years, assembled and processed the information on which this paper is based. This includes staff in the treatment and medical records units of the state hospitals and statistical, clerical, and data-processing staff in the New York State Department of Mental Hygiene. Special thanks are due to Donald Greene for programming consultation.

REFERENCES

1. Weinstein AS, Patton RE: Trends in "chronicity" in the New York State mental hospitals. Am J Public Health 60:1071–1080, 1970
2. Brill H, Patton RE: Clinical-statistical analysis of population changes in New York mental hospitals since introduction of psychotropic drugs. Am J Psychiatry 119:20–35, 1962

Participation in the 1974 Annual Meeting May 6–10, Detroit, Michigan

A form for proposed contributions for APA's 1974 annual meeting was sent to all members in July. An abstract form was provided for those who wish to present a scientific paper, organize a special session or panel, or request the inclusion of a videotape or film. Another form was provided for those who wish to participate as officers of sessions or discussants of papers.

Interested members are urged to return the forms to the Office of the Chairman of the Program Committee, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009, as soon as possible. Persons who are not members may obtain the appropriate forms from the Office of the Chairman of the Program Committee. The final deadline for receipt of the completed forms is September 21, 1973.

Information on submitting papers for consideration for the New Research sessions will be made available at a later time.

EDITORIALS

If They Were Here Now

IF THE 13 MEDICAL SUPERINTENDENTS who founded the American Psychiatric Association were meeting this evening in Thomas Kirkbride's front parlor in Philadelphia, what would they talk about? When they met 129 years ago, they decided to form a group to share knowledge about common problems concerning the care and treatment of their patients. This was an advanced idea, anticipating the present-day interest in continuing education and assurance of quality.

Philadelphia is again finding itself on the cutting edge of the future, but this time some of the changes are being thrust upon the psychiatrist from without. Particularly effective has been the insurance commissioner of Pennsylvania, who has used his authority over Blue Cross contracts to bring about changes generally viewed by the public as very desirable. Hospitals are still doctors' workshops, but the physician is held far more accountable to the public and he works much more under the scrutiny of others. Such enforced regulations as review of all nonemergency admissions within 72 hours for "medical necessity" and refusal to permit collection of charges when the hospital admission is found "not necessary," even if "appropriate," bring to the surface problems and conflicts that must be looked at continuously and carefully.

Scrutiny by their peers provokes some anxiety in physicians generally and provokes a specific irritation when physicians' decisions are questioned. It is no small task to construct guidelines and operate within them. Performing individual case reviews of all patients rather than utilizing sampling techniques consumes a substantial amount of time in "nonproductive" work.

Despite these difficulties, few would deny that more careful consideration is being given to the reasons for hospitalization and the alternative choices of treatment. Also, reviews by peers are providing a very real service as they educate those physicians (fortunately few) who need help to recognize their biases or inadequacies. Such peer review certainly provides a far better guarantee to the public of quality treatment for the individual patient than any number of certificates attesting to the cognitive learning of the psychiatrist. Peer review is also helpful to the psychiatrist when he needs support for an unusual type of treatment.

The Medicaid program in Pennsylvania poses a threat to individualization of treatment because of the possible introduction of a system that would allocate a certain number of days to treat such and such a diagnosis or a particular presenting problem; this system would effectively delimit the kinds of treatment utilizable and would place a physician employed by the state in the deciding position, without the medical appeal that now exists under Blue Cross. Such fitting of the patient to the procrustean bed is the ultimate in dehumanizing that patient.

It is thus easy to see that careful evaluation of the effectiveness of alternative treatments is more than academic. It is regrettable that we have as yet so few discriminating studies, that most of the ones we do have deal with such large and nonspecific groups as to be of little value in regard to individual patients, and that we have not found good measures of individual creativity or group welfare to compare with dollar

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

costs. We need more information to face the real and rational demand that we select treatment modalities wisely.

At the conclusion of their long evening, the 13 superintendents would most certainly decide to meet again the next morning and organize their differences in order that Professional Standards Review Organizations would not go the way of handling a patient as a statistic or of treating him by generalizations. Recognizing that limitless funds are not available in the public arena and that inattention or negativism to problems will force others to determine their future, they would press for responsible and effective peer review to monitor treatment for individual patients. Illness is too painful to leave its treatment to either the inappropriate or the ill-informed.

J. MARTIN MYERS, M.D.

Dr. Myers is Psychiatrist-in-Chief, the Institute of the Pennsylvania Hospital, Philadelphia.

Care of the Chronically Mentally Ill—A National Disgrace

NEWSPAPERS AND PSYCHIATRIC JOURNALS have in recent months featured stories about the great strides in the treatment of severe chronic mental illness. The state hospitals are closing their doors and henceforth all the mentally ill will be treated in the community, it is stated. In New York State, for example, the Department of Mental Hygiene has decreased its inpatient census from 78,000 to 43,000 in five years. Hurrah!

But what has happened to these chronically ill patients—in particular those in the geriatric age range who come from an urban environment? Few have families of their own and many are too mentally dysfunctional to live within a normal family setting. Confused and delusional, they turn to welfare departments to look after them. To further complicate matters, psychiatric units in general hospitals—unable to discharge such patients to state hospitals and unwilling to fill their beds with the chronically ill—refuse them inpatient admission and send them to welfare for care. The burden for care of the chronically mentally ill therefore falls to an already beleaguered, much criticized welfare system.

In New York City, the Department of Social Services attempts to place these patients in whatever settings are available. The aged are referred to nursing homes, where they receive little psychiatric care and no real therapy. Is it therapeutic to send an ambulatory mentally ill person to an environment shared with the severely physically ill and dying, who are largely bed patients? If a mentally ill person in these homes "acts up," he is given a large injection of chlorpromazine, and he too becomes a bed patient. If he decompensates, his return to the state hospital is virtually impossible, and so, more chlorpromazine. Moreover, the ambulatory mentally ill person deprives the physically ill, who need full-time nursing care, of beds, which are in critically short supply. In New York City, where there are over 20,000 nursing home beds, there is a waiting list of 1,500.

New York City has more than 5,000 proprietary home beds, one-half of which are occupied by chronically mentally ill persons. These proprietary homes are largely unsuccessful motels and older hotels that supply room and board but little else. There are no day programs, little recreation, and nobody to even check into the physical well-being of the occupants. These people, many of whom have been in state institutions for 15 years or more, rarely leave the building. They sit and stare into space, and regress as if in the back wards of state hospitals.

On the same day we had referred for our approval to the same proprietary home a 94-year-old woman who had been in a state hospital for 68 consecutive years and a 17-year-old girl who had been hospitalized because of aggressive assaults on others. Even if some program were offered, could one program effectively meet the needs of both these individuals?

The welfare department has initiated a program of boarding mentally disturbed adults with families who have extra space in their homes. Again, there is nothing for the patients to do during the day, and they are too ill to utilize community recreational facilities. Moreover, in a city like New York few families have "extra" rooms, and so the program is limited in scope.

Most of the mentally ill are referred to cheap single-room-occupancy hotels and rooming houses, found largely in the decaying portion of the inner cities. They share this space with prostitutes, discharged prisoners, and drug addicts. As the mentally ill are the weakest group, they fall easy prey to the predators of our society who victimize, terrorize, and otherwise physically abuse them.

What is happening in New York City is happening in other large metropolitan cities across the country where state hospitals have discharged large numbers of mentally ill to communities that have no resources to care for them.

The solution is simple but expensive. We must provide small, centrally located sheltered residences for the chronically mentally dysfunctional. These specialized residences should be funded via the mental health route. There is no real advantage in lumping together the chronically mentally and physically disabled, discharged prisoners, the socially and economically deprived, and mothers with dependent children. The administrative delineation of such specialized groups as the chronically mentally dysfunctional would provide more effective national and local planning and remove the plight of the chronically disabled from the political arena in which the welfare system is currently enmeshed.

There should be a moratorium on "administrative" discharges from mental hospitals. No one who is chronically mentally ill should be summarily discharged to the community unless the community can provide an appropriate and safe place for him or her to live. Those patients unable to physically protect themselves must be protected from the predators in our society; those unable to feed and clothe themselves must be placed in a surrounding where they will be fed and clothed. Those who, because of illness, sit in isolated seclusion must be offered a day program with recreational and sheltered workshop facilities. Those for whom—despite all our known therapeutic interventions—independent life in the community is too anxiety provoking, requiring them to retreat deeper into their illness, must be able to return to a sheltered setting where they can be relieved of their pain.

Freedom to be sick, helpless, and isolated is not freedom. The claim that if there were more formal outpatient psychiatric services, all the mentally ill could effectively manage on their own is faulty. No amount of outpatient service makes the slightest difference to the patient who is too disturbed to travel to where these services may be offered. Despite all our therapeutic zeal, there are many forms of mental illness that are progressive and that do not quickly respond to any treatment. These chronic patients deserve at least as much care as we offer to the acutely ill who improve quickly.

Our present policy of discharging helpless human beings to a hostile community is immoral and inhumane. It is a return to the Middle Ages, when the mentally ill roamed the streets and little boys threw rocks at them.

ROBERT REICH, M.D.

Dr. Reich is Director of Psychiatry, Department of Social Services, New York City, and is on the staff of Mt. Sinai School of Medicine, City University of New York.

BRIEF COMMUNICATIONS

A Criterion Approach to Patient Care Evaluation

BY GARY L. TISCHLER, M.D., AND DONALD C. RIEDEL, PH.D.

The authors describe the application of a criterion-oriented approach to evaluating the quality of patient care in community mental health centers. The basic approach included a review of the care-giving process by a group of expert clinicians, formulation of criteria, their transformation into a "decision-tree" mechanism, and validation through pattern analysis and follow-up studies.

WITH THE GROWTH of the health insurance industry, third-party insurance carriers have become increasingly insistent upon the use of peer review mechanisms to ensure that subscribers to their programs receive appropriate and economical care. More recently, federally sponsored programs such as Medicare have included as a condition for facility participation the monitoring of patient care quality through utilization review. Within this context, the National Institute of Mental Health contracted with the Psychiatric Utilization Review and Evaluation Project (PURE) to develop a basic utilization review program for patient care evaluation in community mental health centers (1, 2).

Utilization review is a mechanism for the continuous monitoring of the propriety, effectiveness, and quality of patient care services. This is accomplished through analyzing patterns of care as well as reviewing individual cases and requires the existence of: 1) an adequate data and information system to record and display patient care information needed for pattern analysis and case review; 2) mechanisms for selecting cases for review that have a high probability of exhibiting care that deviates from the norm; and 3) a review process that not only monitors the quality of care given individual patients but also ensures inputs into program evaluation, program development, and the administrative processes of an institution.

The task of evaluating the quality of patient care is made much easier by the use of criteria. A criterion (a standard against which something can be measured) can be either normative or empirical (3). Normative criteria are formulated on the basis of expert opinion and constructed around an ideal of what represents excellence in clinical practice. Empirical criteria are formulated on the basis of actual patterns of clinical practice as shown by statistical analysis. Both reflect the consensus of clinicians on the state of the art at a given time and represent the operational translation of clinical pragmatism into a set of rules for assessing the quality of patient care. Implicit standards and judgments are made explicit by guidelines that delineate the limits of appropriate, adequate, and effective care.

In this paper we will briefly describe the criterion-oriented approach adapted by PURE, consider some general issues related to the formulation of criteria, and present examples of formulated criteria.

A CRITERION-ORIENTED APPROACH

The project's approach to criteria development began by calling together a group of mental health workers representing several disciplines. They were charged with formulating normative criteria for use in evaluating the quality of patient care at a specific mental health center. The group examined various facets of the care-giving process through the careful review of patients' written records. The opinions and observations of the members were recorded and reflected the clinical experience, knowledge of the literature, and personal and professional biases of the participants. The group served as a

This article is a revised version of a paper read at the Second Annual Alcoholism Conference of the National Institute on Alcohol Abuse and Alcoholism, Washington, D. C., June 1–2, 1972.

The authors are with the Yale School of Medicine, Department of Psychiatry, 34 Park St., New Haven, Conn. 06519, where Dr. Tischler is Associate Professor of Clinical Psychiatry and Dr. Riedel is Professor of Public Health (Medical Care).

This work was supported under Public Health Service contract HSM-42-69-60 from the Health Services and Mental Health Administration, Department of Health, Education, and Welfare. It was part of the Health Services Research Program, Institution for Social and Policy Studies, Yale University.

catalyst that forced each participant to clearly articulate the pertinent factors influencing his individual judgments. As a result, implicit norms were translated into explicit standards. More charts were then reviewed and the standards refined into criteria for various aspects of the care-giving process.

The normatively derived standards were then subjected to testing by pattern analysis and outcome studies. Pattern analysis was used to identify homogeneous groupings of patients who received similar patterns of care and to see whether these patterns conformed to the normative standards the group had established. Using length of stay as the dependent variable, we found that the major factors affecting deviation from usual patterns of care included social class, town of residence, age, and admitting diagnosis. For example, one homogeneous group comprised patients in Hollingshead and Redlich's social classes I–IV between the ages of 16 and 20 residing in the suburban New Haven area, with an admitting diagnosis of functional psychosis. Since a diagnosis of functional psychosis in an adolescent is one criterion for hospitalization, the analysis confirmed the fact that, for this group of patients, observed practices conformed to normative standards.

A second method for testing normative standards empirically is the use of outcome and follow-up studies. Such studies enable investigators to check "expert opinion" regarding the quality of care against what actually happens to patients after they leave a treatment setting. Relationships among patient attributes, characteristics of treatment and outcome measures of mental status, social adjustment, role performance, and postdischarge treatment status can be documented. As a result, data are provided that can be applied not only to constructing and/or modifying criteria, but also to evaluating the relationship between institutional standards and postdischarge performance.

At the same time the empirical testing of criteria was undertaken, another group organized the newly developed criteria into a case record abstract. The abstract was intended to facilitate case review by providing a basic instrument for evaluating the quality of patient care. Constructed as a "decision tree" that measured the logic and consistency of the evaluative, treatment, and disposition processes, it took the form of a checklist with yes-no questions on quality of care.

In summary, the basic elements of the criterion approach used by PURE consist of review of the care-giving process by a group of expert clinicians, formulation of criteria and their transformation into a decision-tree mechanism for measuring the quality of patient care, and validation of the criteria through pattern analysis and follow-up studies.

CRITERIA AND THE QUALITY OF PATIENT CARE

While the panel considered various aspects of the care-giving process discretely, it was clear that the quality of patient care was viewed as a function of its appropriateness, adequacy, and effectiveness. To be appropriate, the allocation of services should be congruent with admission standards. To be adequate, the care-giving process should include those methods which are consistent with and required by the presenting problem. The treatments themselves should be within the bounds of legitimate conduct. To be effective, care should be associated with attaining specified objectives for the presenting problem.

Criteria of appropriateness provide guidelines for admission to treatment services. In general medicine, such criteria are formulated on the basis of diagnosis, but diagnosis is not necessarily the best point of departure in psychiatry. Not only is the relationship between diagnosis and prescribed treatment far from absolute, but the reliability of clinical diagnosis (repeatability over time or observer consistency) is also open to question (4–9).

Advances have been made that increase the reliability of diagnoses through the use of computer technology (10), the development of diagnostic rating scales (11–13), and symptom categorization techniques (14, 15). However, PURE's experience suggests that the most economical approach to formulating criteria of appropriateness in general psychiatry is through linking the measures of psychosocial, environmental, and biological functioning to broad treatment categories such as inpatient, partial hospitalization, or outpatient care.

For example, at one center involved in the project, the staff made suicidal behavior the basis for criteria providing guidelines for compulsory hospitalization (appendix 1). At a second center, the appropriateness for admission to a long-term psychotherapeutically oriented group treatment program was presented in terms of criteria for inclusion and exclusion (appendix 2). As these appendices indicate, criteria for the appropriateness of psychiatric treatment usually take into account a number of factors other than diagnosis. They may be formulated in terms of indications or contraindications. A single criterion may be presented as a requirement for admission, or the criteria themselves may be used to establish parameters against which clinical judgment can be tested.

Criteria of adequacy focus on the treatment process itself. They are intended to ensure that at least minimal standards govern the implementation of a treatment program.

At one center, parental involvement was required in the treatment of adolescents unless: 1) the patient's life situation was not judged chaotic, 2) the patient was an emancipated minor, or 3) parental involvement during the initial phase of treatment was felt to endanger the development of a therapeutic alliance. At the same center a neurological examination or an examination by a neurological consultant was required for a hospitalized patient if the admission work-up revealed a history of fainting, periodic headaches, vertigo, seizures, head trauma, fugue states, episodic violence, or impairment of consciousness, orientation, or cognitive function.

The staff of another center developed diagnosis-specific guidelines for the use of psychotropic medications. For each medication maximal dose levels were es-

tablished, time spans within which a medication regime had to be reviewed were developed, and a program for baseline and sequential laboratory studies was formulated. The use of electroconvulsive therapy was limited to patients who failed to respond to other treatments but still exhibited life-threatening behavior.

These examples indicate that criteria of adequacy establish standards of legitimate clinical conduct within the context of specific treatment methods and provide guidelines that indicate the treatments required by and consistent with various diagnosed problems and the alternative intervention to be taken if the initial treatment proves unsuccessful. The criteria themselves may be specific to the population, problem, method, or program. They are intended to ensure that the treatment process unfolds in a rational and systematic manner.

Criteria of effectiveness are intended to measure the success or lack of success of a particular treatment sequence. The criteria themselves are stated as intermediate goals that can realistically be achieved during the course of an intervention. The centers involved in the project have addressed themselves primarily to the issue of effectiveness from a program-specific perspective. Thus the effectiveness of a medication maintenance program for chronically ill psychiatric patients was measured by the degree to which program involvement was associated with either the prevention or the reduction of psychiatric hospitalizations and/or acute exacerbations of psychotic states. The criteria of effectiveness for an alcoholism detoxification and rehabilitation program were: 1) the resolution of concrete dilemmas in living such as legal, financial, housing, or employment problems; 2) improved family relations; 3) a more stable work record, where applicable; and 4) the individual's ability to control drinking over progressively longer time spans.

Alternatively, the question of effectiveness can be approached from a patient-specific rather than a program-specific perspective. Hogarty and Ulrich have developed an inventory that provides a valid predictor of discharge readiness for hospitalized patients (16, 17). Kiresuk and Sherman use a technique that establishes, before treatment, a measurable scale for each patient-therapist goal and specifies, for each patient, a transformation of overall goal attainment into a t score (18). Goal achievement approaches have been applied routinely by behavioral therapists (19). They have also been used for measuring the effectiveness of drug therapies in "the eradication of target symptoms" (20).

Where a patient-specific, goal-achievement approach is adopted for measuring effectiveness, one needs to define presenting problems in objective terms, develop behavioral goals toward which therapeutic change can be directed, and establish a continuing system for measuring the direction and magnitude of change. Whether or not criteria of effectiveness are formulated from a patient-specific or program-specific perspective, however, attention must be paid to specifying endpoints that can be measured if a reasonable degree of predictive validity is to be ensured.

CONCLUSIONS

We recognize that a set of standards cannot be imposed upon an institution when the state of the art is such that great variation exists both in the definition of what represents mental disorder (or mental health) and in clinical approaches to patient care. Rather, it is the function of a criterion-oriented approach to ascertain whether the care given corresponds to the manifest goals of a service institution as formulated in a set of standards or guidelines related to the quality of patient care.

Where a criterion-oriented approach is used, implicit norms must be translated into explicit standards. It then becomes possible to detect not only cases in which patient care deviates from desired norms but also cases in which patient care has conformed to treatment standards and yet the outcome has been unsatisfactory. As a result, the use of a criterion approach provides a vehicle for clarifying issues related to patient care that are now conceptually unclear and for monitoring the quality of care given by a wide variety of service institutions.

REFERENCES

1. Riedel DC, Brauer L, Brenner MH, et al: Utilization review and evaluation in a community mental health center. Hosp Community Psychiatry 22:229–232, 1971
2. Riedel DC, Brenner MH, Brauer L, et al: Psychiatric utilization review as patient care evaluation. Am J Public Health 62:1222–1228, 1972
3. Donabedian A: Evaluating the quality of medical care. Milbank Memorial Fund Quarterly 44:166–206, 1966
4. Beck AT, Ward CH, Mendelson M, et al: Reliability of psychiatric diagnoses. Am J Psychiatry 119:351–357, 1962
5. Ward CH, Beck AT, Mendelson M, et al: The psychiatric nomenclature: reasons for diagnostic disagreement. Arch Gen Psychiatry 7:198–205, 1962
6. Babigian HM, Gardner EA, Miles HC, et al: Diagnostic consistency in a follow-up study of 1,215 patients. Am J Psychiatry 121:895–901, 1965
7. Schmidt HO, Fonda CP: Reliability of psychiatric diagnosis: a new look. Journal of Abnormal and Social Psychology 52:262–267, 1956
8. Silverman C: The Epidemiology of Depression. Baltimore, Johns Hopkins Press, 1960
9. Kendell RE, Cooper JE, Gourlay JRM, et al: Diagnostic criteria of American and British psychiatrists. Arch Gen Psychiatry 25: 123–130, 1971
10. Spitzer RL, Endicott J: DIAGNO II: further developments in a computer program for psychiatric diagnosis. Am J Psychiatry 125:12–21, 1969
11. Lyerly SB, Abbot PS: Handbook of Psychiatric Rating Scales (1959–1964), National Institute of Mental Health, Public Health Service Publication 1485. Washington, DC, US Government Printing Office, 1966
12. Astrachan BM, Adler D, Brauer L, et al: A checklist for the diagnosis of schizophrenia. Br J Psychiatry 121:529–539, 1972
13. Selzer ML: The Michigan alcoholism screening test: the quest for a new diagnostic instrument. Am J Psychiatry 127:1653–1658, 1971
14. Robins E, Guze SB: Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. Am J Psychiatry 126:983–987, 1970
15. Feighner JP, Robins E, Guze SB, et al: Diagnostic criteria for use in psychiatric research. Arch Gen Psychiatry 26:57–63, 1972
16. Hogarty GE, Ulrich R: A Manual for Discharge Readiness. Baltimore, Friends Medical Service Research Center, 1971
17. Hogarty GE, Ulrich R: The discharge readiness inventory. Arch

Gen Psychiatry 26:419–426, 1972
18. Kiresuk TJ, Sherman RE: Goal attainment scaling: a general method for evaluating comprehensive community mental health programs. Community Ment Health J 4:443–453, 1968
19. Moss GR, Boren JJ: Specifying criteria for completion of psychiatric treatment. Arch Gen Psychiatry 24:441–447, 1971
20. Hesbacher PT, Rickels K, Weise C: Target symptoms. Arch Gen Psychiatry 18:595–600, 1968

APPENDIX 1

Criteria for the Hospitalization of Patients Exhibiting Suicidal Behavior

If the patient exhibited any of the following, was he hospitalized (compulsory if necessary)?

1) current, clear suicide attempt
2) a clear, lethal suicide plan
3) a recent history of medically serious attempts
4) suicidal thoughts, gestures, or attempts in association with delirium or psychosis
5) recent marked progression in seriousness of thought or from thought to gestures
6) expression of strong suicidal thoughts with intent and without seeing another way out
7) an expectation of hospitalization that cannot be changed at interview
8) expectation not met of change in behavior of significant others due to suicidal behavior nor can change be accomplished appropriately
9) precipitating factor cannot be changed
10) high risk social circumstances

APPENDIX 2

Criteria for Admission to Long-Term Psychotherapeutically Oriented Group Treatment

If the patient has any of the following characteristics was he excluded from consideration for long-term group treatment?

1) diagnosis of organic brain syndrome
2) diagnosis as paranoid
3) acutely suicidal
4) acutely homicidal
5) described as acutely psychotic in the intake or admission note
6) hallucinating
7) inappropriate affect
8) low intellectual development
9) poor impulse control
10) external factors (going to leave the area soon, etc.)

If the patient had any of the following problems was he assigned to a long-term group or, if not, was an explanation provided?

1) primary problem was interpersonal
2) a personality disorder other than paranoia
3) severe dependency problems
4) sociopathic

Group Process Research: A Factor Analytical Study

BY DAVID M. HAWKINS, M.D., C. BRYAN NORTON, M.D., CARL EISDORFER, M.D., PH.D., AND DANIEL GIANTURCO, M.D.

In order to gain a clearer understanding of the treatment process in group therapy, the authors devised a questionnaire for observers to use in describing group sessions. After subjecting these observations to factor analysis, five distinct factors were identified and related to the behavior of the subject groups. Possibilities for further investigation include the profile of the successful group and identification of leadership style effects. It is suggested that identifying the components of each factor will aid the understanding of conditions that lead to its variation in a specific profile.

FOR A RATIONAL APPROACH to patient care we must subject group psychotherapy, along with all other forms of psychiatric treatment, to studies of both outcome and the treatment process. Given the many theories of process in group treatment, investigators need more precise methods of describing the process so that significant common elements can be identified and related to other variables. This study reports on one approach to this problem, a factor analysis strategy that can be used to describe the climate in individual groups or group sessions.

Retrospective studies using subjective descriptions of the group experience have indicated that the climate or

Dr. Hawkins and Dr. Norton are Associates in Psychiatry and Dr. Gianturco is Associate Professor of Psychiatry and Assistant in Community Health Science, Duke University Medical Center, Durham, N.C. 27706. Dr. Eisdorfer is Chairman and Professor of the Department of Psychiatry, University of Washington, Seattle, Wash.

culture of the group is related to therapeutic outcome. Dickoff and Lakin (1) found that more than 50 percent of the patients in their study considered a feeling of mutual support to be the most important aspect of the group. Yalom (2) made a strong case that cohesiveness is a major therapeutic element. Subjective evaluation of such a climate or cohesive element by simple observation does not ordinarily permit quantification, statistical reliability, or tests of relatedness to other variables. An alternate approach to the definition of group process includes the systems suggested by Bales (3) and by Borgatta and Crowther (4) for recording and classifying in detail the interactions in the group. These methods are cumbersome and meet a pitfall that Psathas (5) suggested is present in much group process research, i.e., trying to fit the elements of interaction into predetermined categories rather than letting the classification come from observation.

Given this criticism, a method using factor analysis is particularly appropriate. It helps organize observations of the rather vague quality, "group climate," into defined factors but keeps predetermination of categories that might bias observations to a minimum.

TABLE 1
Item Factor Loading in Each Group Factor

Item Description	Loading Factor
Factor I	
The members of this group are very candid	.828
The members of this group talk freely about problems	.754
There is a lot of group spirit in this group	.739
There is a lot of honesty expressed in this group	.737
This group pays a lot of attention to what the leaders say	.727
Individuals are told how others see them	.717
A member who is depressed would probably feel better in this group	.690
Individuals seem free to say what they feel or how they react to something	.680
This is a very friendly group	.659
A member of this group is expected to show improvement	.638
There is a very trusting atmosphere in this group	.529
The members of this group are very manipulative	.527
The members of this group are very angry	.521
There is a lot of laughing and joking in this group	.516
Each person in this group wants his problem to be seen as the most important	.513
Factor II	
The members of this group avoid confronting others	−.705
The members of this group are well motivated	.680
This is a very dull group	−.648
It's hard for a group member to get across what he is trying to say	.613
The members of this group are willing to share secrets about themselves	−.612
People in this group really listen to each other	.577
This is a very uninhibited group	.446
Factor III	
Most individuals seem to have a pretty good idea of their therapeutic goals	−.668
This group works with issues left over from the last session	−.651
Most of the members of this group feel it is up to them to solve their problems	−.605
The members of this group avoid important issues	.571
Each person in this group wants his problem to be seen as the most important	.500
Factor IV	
The members of this group readily express negative feelings toward each other	−.677
The group talks about ideas more than feelings	.571
People are more likely to agree with an individual's description of his troubles than to challenge him	.564
Factor V	
This is an exciting group	−.712
The members of this group show concern for each other	−.656
There is lively interaction in this group	−.654
This is a hardworking group	−.562

METHOD

The Questionnaire

To aid the observers of the subject groups in providing consistent descriptions of each session a questionnaire was devised. We compiled a list of descriptive statements one might commonly make about a group in forming impressions of feeling ("there is a friendly atmosphere in this group"; "the members of this group are very angry") or making observations of interaction ("these people interrupt each other a lot"; "when people in this group get mad they shut up"). We wanted a large number of distinct items to permit observations of a broad range of interactions and feelings and to provide for the later elimination of items that were redundant or of little descriptive value. Items that required judgment based on theoretical knowledge were avoided. Three psychiatrists and two psychologists experienced in group psychotherapy were asked to judge the clarity and comprehensiveness of the observations and to suggest additions or deletions. The final list contained 65 statements. Each item was to be rated by the observer on a four-point scale according to whether the statement applied to the session he had observed: "none or a little of the time," "some of the time," "a good part of the time," or "most or all of the time."

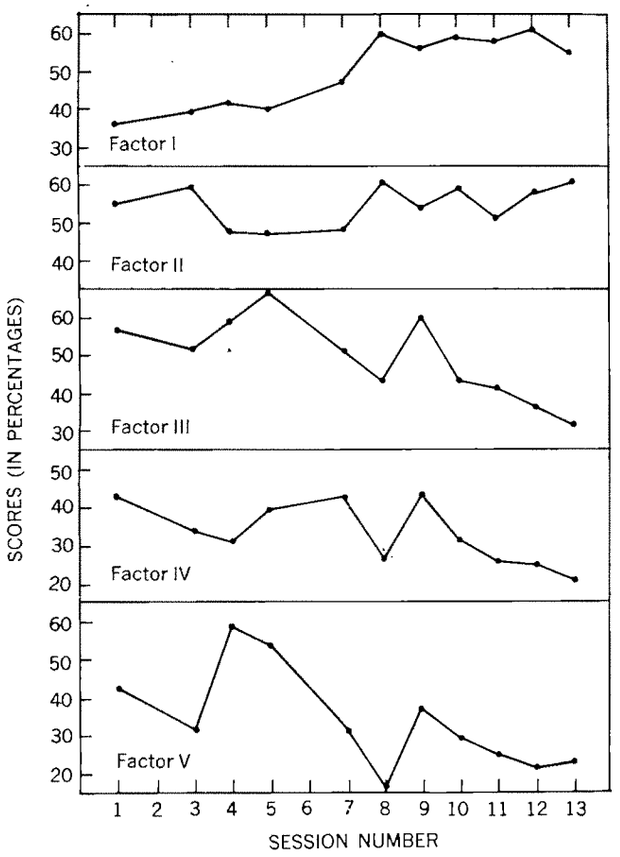
Subject Groups

Four short-term therapy groups in the psychiatric outpatient clinic of a university medical center were used in this study. The only patient selection criterion was exclusion of those unable to interact meaningfully with others. The goals of the groups were resolution of situational problems, clarification of interpersonal problems, and determination of further therapeutic needs. Each group consisted of four to eight members and met for an hour and one-half weekly for 13 sessions.

Procedure

Each group session was observed through a one-way mirror by a group therapy instructor and five to ten second-year psychiatric residents, who served as the observ-

FIGURE 1
*Alignment of Factors Over 13 Sessions in Group 1**



*Since scores represent a percentage of the maximum possible factor weight, those factors with fewer items show a wider range of movement.

ers. In total, there were 18 different observers. Immediately following each session the instructor met with the observers and group leaders for a half-hour discussion. During the first ten minutes of the discussion period, each observer independently completed the questionnaire for the group session he had just witnessed.

RESULTS

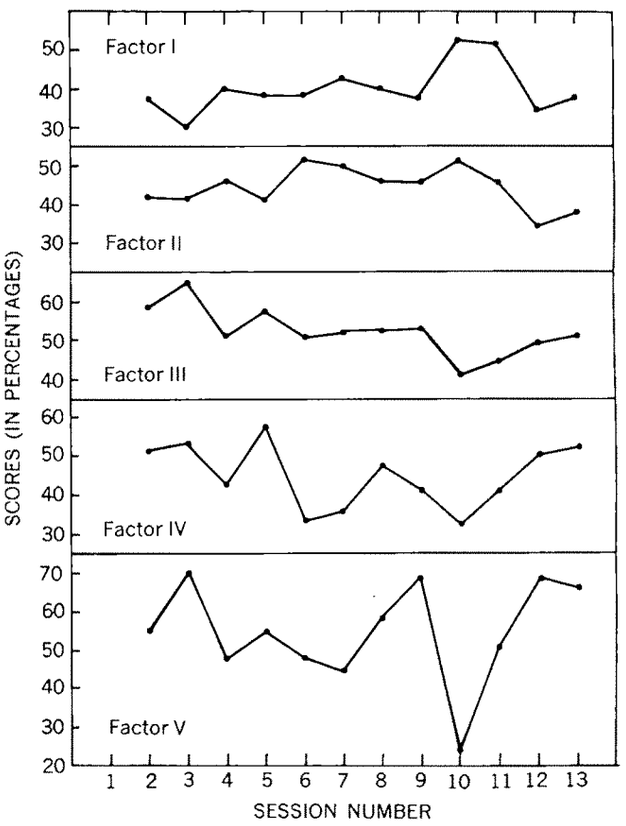
A total of 339 questionnaires were completed following observation of the four groups after each of 13 sessions. Ratings on the 65 questions were analyzed using the factor-vector analysis technique with an oblique rotation in the R mode. Only the first five factors were used for this study since they accounted for 74 percent of the cumulative variance. The lowest factor loading used on any scale of the five factors was set as 0.50; at that loading only one of the questions appeared in more than one factor (see item 15 in factor I and item five in factor III, table 1). Thirty-three questions fit these rather rigid criteria and were used in subsequent measurements of the five factors.

Interobserver reliability was determined by comparing the factor score ratings of two observers for each session of each of the four therapy groups. Pearson product-moment correlations were computed for each factor. They were: factor I: $r=0.39$; factor II: $r=0.71$; factor III: $r=0.20$; factor IV: $r=0.39$; and factor V: $r=0.76$. The average was $r=0.49$, which is an acceptable level of reliability. These reliability ratings will improve as the observers gain more training and experience.

The Factors

The individual descriptive items contributing to the five factors, along with their factor loadings, are presented in table 1. After setting the cutoff point of 0.50 for the individual scale in each factor, 33 items were identified. As a result of using this relatively high cutoff, only one of the items is repeated in two factors. Each of the factors is therefore distinct. On the basis of those items with the highest loading within each factor, we can describe the five factors (in unidimensional terms) as follows: factor I—expressive, supportive; factor II—confronting, hardworking; factor III—directionless,

FIGURE 2
*Alignment of Factors Over 13 Sessions in Group 4**



*Since scores represent a percentage of the maximum possible factor weight, those factors with fewer items show a wider range of movement.

lacking responsibility, and self-oriented; factor IV—avoiding confrontation and feelings; and factor V—dull, apathetic, and noncohesive.

The appearance of each of these elements in a particular group session can be quantified from the observer ratings of that session. The five factors together form a profile of the "group climate," with each factor representing one of its measurable elements.

It is of particular significance that over the life of the group the factors appear to vary in relation to each other and in accord with the observers' impression of what is happening in the group. As can be seen in figures 1 and 2 (representing the first and fourth groups), factors I and II are closely related and peak at times when the group is in a productive, cohesive working phase. The other three factors are more aligned with phases in which the group is facing obstacles or resistance to work. A finer delineation of what each scale and profile means in a particular instance will require more data from other groups.

DISCUSSION

It has been the purpose of this study to develop an evaluative scheme for investigating the nature of group process. The scheme reflects the "climate" of therapy groups with their shifting themes, concerns, problems, and strengths, as seen by professional observers. These observations have been analyzed using a factor-analytic approach and the results indicate that five separate factors can be designated.

In subsequent evaluations using this approach, it can be expected that one or another factor will be dominant in a group either for its entire course or for an individual session. By quantifying that dimension, looking at the degree of its dominance and its movement in relation to itself and other dimensions, we can plot the nature of the group's interaction. For example, factor I varies along a dimension of openness, support, and morale, while factor II independently indicates an aggressive, challenging, and investigative dimension. Thus a group could be strongly supportive and expressive (a predominance of factor I in a positive direction) and at the same time more or less challenging and investigative. In the groups observed, factors I and II tended to vary together, but this need not always be the case. A group might score high on factor I (support and morale) and factor IV (indicating intellectual flight), with factor II varying in a negative direction toward lack of confrontation and investigation.

Using these factors we can now make hypotheses about interactions in groups. For instance, as a difficult problem is approached, we might expect a rise in self-centered (factor III) and avoidance (factor IV) behavior and decreasing group cooperation and morale (factor I). As the problem is confronted and handled (perhaps with a rise in factor II) we might expect openness and support (factor I) to rise again. It would be interesting to define "successful" and "unsuccessful" groups and then look for patterns in their profiles, expecting perhaps that the "unsuccessful" group would show less working through and persistently high values for the nonresponsible, self-centered, avoiding, apathetic dimensions.

Yalom and Lieberman (6) have examined the effect of leadership styles on T groups. It would be useful to explore the effect of various leaders on group profiles and relate this to outcome. We might expect, for instance, that the "charismatic" leader would help the group overcome obstacles, but without raising morale and investigative qualities (factors I and II) and perhaps increasing the self-centered and nonresponsible dimension (factor III).

Further investigative possibilities should result, since the factors are so distinct. It should be possible to identify the components of each factor to better understand what conditions lead to its variation in a specific profile. To do so is important for understanding and evaluating group psychotherapy and ensuring that it is a valid form of treatment.

REFERENCES

1. Dickoff H, Lakin M: Patients' views of group psychotherapy: retrospections and interpretations. Int J Group Psychother 13:61–73, 1963
2. Yalom ID: The Theory and Practice of Group Psychotherapy. New York, Basic Books, 1970
3. Bales RF: Interaction Process Analysis. Cambridge, Addison-Wesley, 1951
4. Borgatta EF, Crowther B: A Workbook for the Study of Social Interaction Processes. Chicago, Rand McNally, 1965
5. Psathas G: Overview of process studies in group psychotherapy. Int J Group Psychother 17:225–235, 1967
6. Yalom ID, Lieberman MA: A study of encounter group casualties. Arch Gen Psychiatry 25:16–30, 1971

Group Psychotherapy Supervision and Its Effect on Resident Training

BY WILLIAM K. GROSSMAN, M.D., AND EDWARD KARMIOL, PH.D.

The authors describe their experience with three models of group therapy supervision and their effects on resident trainees. Advantages and disadvantages of the models are discussed. The authors suggest that the use of variable models would meet different trainees' needs, ensuring optimal conditions for learning and therapy and minimal resistance to supervision.

FROM OUR WORK with three models of group therapy supervision and their effect on trainees, we have concluded that certain limitations of a psychotherapeutic situation are rooted in the nature and essence of a particular supervisory relationship. Advantages and disadvantages of each supervisory model will be discussed.

Group psychotherapy supervision attempts to aid the supervisee in the solution of group process problems by suggesting various techniques, strategies, and methodologies. In addition, the supervisor, simply by being the person he is and by handling the problems presented to him as he does, demonstrates a style, a way of functioning, that can be learned and incorporated into a therapeutic repertoire. It is important for the supervisor to teach, instruct, and demonstrate. At the same time it is equally important for him to allow the supervisee an opportunity to grow and develop, to become as fully as possible his own therapeutic self. The stance the preceptor takes with those he is training, then, can stimulate and augment the approach the therapist takes with the patients he is treating.

SUPERVISION

Just how the preceptor supervises a trainee in group therapy is subject to considerable variability. Different supervisors go about their work in different ways, and a given supervisor may employ different teaching models. As a supervisor of group psychotherapy, one of us (E.K.) has employed three basic models of supervision. An attempt will be made to describe these models and to discuss some of the pros and cons involved in their utilization.

At the time this work was done the authors were with the Institute of the Pennsylvania Hospital, Philadelphia, Pa., where Dr. Grossman was Psychiatric Resident and Dr. Karmiol is Special Consultant, Group Therapy Program. Dr. Grossman is now Fellow in Medical Education, Jefferson Medical College, Philadelphia, Pa. Address reprint requests to Dr. Grossman at 440 South 43rd St., Philadelphia, Pa. 19104.

The Supervisor-Therapist Model

In this model the supervisor joins the trainee as part of the therapy team and meets regularly with the group. After each treatment session supervisor and supervisee meet for rehash sessions that allow for discussion of the therapeutic behavior elicited by the group. However, the supervisor is generally considered to be the primary therapist, and the group more or less "belongs" to him. This model of training seems to be most effective when the supervisee has a high regard for the supervisor and wishes to learn and to be a similar kind of therapist. In such instances identification or therapeutic modeling readily takes place. In those instances in which regard is not high or not significantly present, or in which the supervisee wants more freedom to do his own thing, friction and resentment readily accrue. It is wise, whenever possible, to work out these differences to the fullest extent possible. Chronic dissatisfaction and competition make it difficult to stay attuned to the problems and processes of the group itself.

The Supervisor-Observer Model

The supervisor observes the therapy team and group (usually behind a one-way mirror) but does not intervene in the actual treatment session. The group therapist meets with the supervisor after the session to discuss the experience. Usually the therapist and patients quickly adapt to the idea of being observed. This model of training allows the supervisor to see and hear the group in action (a sense of the group interaction is quite different in and out of the treatment room) and to directly observe what the trainees are doing. It is a firsthand account of what is occurring. However, the supervisory sessions will most likely focus upon what the preceptor has observed, what the therapists have missed or misperceived, and what alternative, more adequate responses might be made. Consideration of what the therapists might be struggling with and need to talk about is put aside so that the more "valuable" observations of the supervisor can be presented. In a sense the therapists are not allowed to develop their own phenomenology of the group. The therapists themselves can (defensively) foster this arrangement. As long as he remains an observer the preceptor may find himself hard pressed to bypass, if only momentarily, his ideas about what went on.

The Supervisor Apart from the Group Model

In this model there is no direct connection between supervisor and group. The supervisor does not function as therapist in the group or as observer of the group. How-

ever, he does meet with the therapy team after each group session to discuss the responsibility of the trainees, which they themselves determine. This training model focuses on the trainees and what they perceive as their strengths and weaknesses with a given group. What is available to the supervisor is the account presented to him and the behavior exhibited by the trainees within the context of supervision. Essentially, the supervisor is limited to working with the same kinds of material that the therapist must work with as he treats his patients.

CLINICAL EXPERIENCE

What follows are one therapist's responses to a variety of supervisory situations and observations.

The Supervisor-Therapist Model

Late in the first year of psychiatric residency one of us (W.K.G.) had a six-month experience doing multiple therapy as a junior cotherapist with a staff psychiatrist. The division of responsibility was not well defined. As the year progressed, I became restless and wanted more freedom to develop my own therapeutic style; the sessions became more tedious.

Early in the second year I had a six-month experience as a junior cotherapist doing family therapy with a staff physician. As in the previously described situation, I had a high regard for the therapist and used him as a role model. This time, however, I was content to remain the junior therapist.

The Supervisor-Observer Model

Later in the second year of my residency another cotherapist, a resident, and I started an adult outpatient therapy group. It was supervised, with alternate weeks of immediate supervision after the group meeting and supervision at a later date. It was observed every week.

During the weeks of immediate supervision, after the group meeting both my cotherapist and I felt as if "there was someone in our living room." Conscious efforts to please the supervisor were evident, our growth toward our own therapeutic style was impeded, the supervision was directed toward what the supervisor saw, and we eventually became resentful of the supervision. We made less of an effort toward a cotherapy relationship after these sessions.

During the weeks when supervision occurred at a later date our sense of flexibility and spontaneity remained impaired, but not to the extent it had in immediate supervision. We spent more time in our cotherapy relationship, we experienced a greater sense of responsibility for what happened in the group, and we used the supervisor more for helping us deal with what we perceived as problems. As this group continued we became less conscious of the observer-preceptor, and we gradually felt more freedom.

The Supervisor Apart from the Group Model

Early in the second year of my residency my cotherapist and I started an adolescent inpatient therapy group. My cotherapist, a nurse, had had experience in participating in group therapy as well as two months' experience as a cotherapist. We both participated in two group therapy seminars. This group was supervised but not observed by the preceptor. My cotherapist and I experienced a greater sense of responsibility for the group than we would have felt if we were being observed. We used the supervisory time to deal with what we perceived were problems in the group and our cotherapy relationship. We both found a great sense of flexibility.

CONCLUSIONS

We suggest that preceptors be able to use multiple models of supervision. Use of variable models would meet different trainees' needs, ensuring optimal conditions for learning and therapy and minimal resistance to supervision. It would also allow the trainee to develop his own therapeutic style. These observations on training might apply to other medical disciplines as well.

Methylphenidate in Tardive Dyskinesia

BY WILLIAM E. FANN, M.D., JOHN M. DAVIS, M.D., AND IAN C. WILSON, M.D.

Methylphenidate, an amphetamine-like central nervous system (CNS) stimulant used successfully in reversing acute neuroleptic-induced neurological symptoms, was given in a placebo-controlled study to 17 patients with tardive dyskinesia. On global ratings three subjects were improved, six showed an increase in symptoms, and eight showed no changes. The authors conclude that methylphenidate is not effective in tardive dyskinesia and that the results of this study are in keeping with present knowledge about CNS pharmacology.

TARDIVE DYSKINESIA, a hyperkinetic state resulting from prolonged exposure to neuroleptics (1–4), has proven difficult to treat pharmacologically. A variety of agents have been used in attempts to reverse the condition. Patients most likely to display tardive dyskinesia are those whose treatment with neuroleptics is withdrawn after long exposure; continued therapy tends to mask or reduce the symptoms (5, 6). On the basis of this evidence, some investigators have given high doses of phenothiazines, especially the piperazine derivatives (7, 8), as well as haloperidol (9, 10) in treating these conditions. Others have tried the potent biogenic amine-depleting agent reserpine (11, 12) and its congener tetrabenazine (13) with some success. Amantadine, an antiviral agent with mild central nervous system (CNS) stimulant properties, has also been suggested (14) but the findings from these investigations and the criteria on which they were based have been challenged (15). The vitamin pyridoxine has been tried, but also without success (16). A precursor of dopamine, levodopa, used successfully in treating parkinsonism, has provided no help in tardive dyskinesia (17), nor has methyldopa, a compound known to compete with levodopa in vitro and a commonly used antihypertensive, shown any clear effects in relieving tardive dyskinesia (18).

Since the condition seems to be brought about by prolonged exposure to neuroleptics and since some of the predominant activity of these compounds is to block central adrenergic mechanisms, it would therefore seem reasonable to use a drug that has central adrenergic stimulant properties. For this reason we tried caffeine, amphetamine, and methylphenidate. Methylphenidate has been used successfully to reverse the acute neurotoxic side effects of phenothiazines (19). Pilot studies in tardive dyskinesia showed no response to caffeine or amphetamine but some modest improvement with methylphenidate, a tertiary amine with central stimulant properties similar to those of amphetamine (20, 21). Because methylphenidate reverses some of the acute neurotoxic effects of neuroleptics and because our own pilot study suggested that it may be effective in tardive dyskinesia, we undertook a double-blind, placebo-controlled study using regular daily oral doses of this agent. This is a report of that study.

METHOD

A group of 30 hospitalized patients diagnosed by independent clinicians as having tardive dyskinesia were taken into the study. EKG, physical examination, blood studies, and urinalysis were performed before and after the treatment period. Daily blood pressure and pulse readings were recorded. The patients were housed on their regular treatment wards and escorted once a week to the office of the rater, where they were examined for ten minutes each and rated on Crane's neurological scale.[1] For us this method has demonstrated high reliability. The Nurses' Observation Scale for Inpatient Evaluation (NOSIE–30)[2] forms were completed weekly by the ward aides. Global ratings were made from verbal reports collected from the ward staff and other observers of the patients' overall functioning and ability to carry out activities of daily living. Videotapes were made of each subject before, during, and after treatment, rerun in random sequence, and rated blind. Half the subjects were randomly placed in the placebo group and half received the active drug. All subjects began by receiving 20 mg. of methylphenidate per day (or its placebo equivalent) and

Dr. Fann is Assistant Professor, Department of Psychiatry and Pharmacology, Duke University Medical Center, P.O. Box 3812, Durham, N.C. 27710, and Staff Psychiatrist, Veterans Administration Hospital, Durham; Dr. Davis is Professor of Psychiatry and Associate Professor of Pharmacology, Department of Psychiatry and Pharmacology, Vanderbilt University Medical School, Nashville, Tenn.; and Dr. Wilson is Research Psychiatrist, Dorothea Dix Hospital, North Carolina State Department of Mental Health, Raleigh, N.C.

This work was supported in part by Public Health Service grants HE-05545 and HE-10842 from the National Heart and Lung Institute, GM-23168 and GM-15431 from the National Institute of General Medical Sciences, and RR-0009510 from the Division of Research Resources, National Institutes of Health.

The authors wish to thank Mr. John F. Kitchen, Medical Research Associate at CIBA-Geigy, which furnished methylphenidate and its placebo.

[1] Neurological Rating Scale. NIMH Collaborative Study on Tardive Dyskinesia, by George Crane, M.D.

[2] Copyright Gilbert Honigfeld, Ph.D., Research Department, Hillside Hospital, Glen Oaks, N.Y., 1966.

the dosage was increased for each by equal weekly increments to a maximum of 80 mg. per day. At the end of six weeks the two groups were crossed over. All subjects continued to receive their prescribed neuroleptics: 200–800 mg. of chlorpromazine per day or its equivalent (22); the phenothiazines were the only neuroleptics used.

RESULTS

Seventeen of the 30 subjects completed the full 12 weeks of the study. Of the remaining 13 patients, five displayed an increase in psychiatric symptoms, became unruly or unmanageable, and were removed from methylphenidate treatment; eight others were removed from the study for administrative reasons. The 17 who completed the study were compared on several ratings between methylphenidate and placebo.

The weekly blind ratings showed no definite or consistent changes in the neurological symptomatology for either group at any time. The NOSIE scales for those patients remaining in the study showed no significant changes. No differences were found from serial assessment of the videotapes. On the global weekly neurological ratings by the nurses and ward staff, six patients showed some increase in hyperkinesia, eight showed no change, and three were judged to be improved while taking methylphenidate. These three became able to feed themselves, tie their shoestrings, carry cafeteria trays, and dress themselves. This improvement was lost when methylphenidate was withdrawn.

Side effects included a transient (five-day) rise of 20 mm.Hg in the systolic blood pressure of one patient, transient moderate (trace–2+) proteinuria in five women patients, and EKG changes that had no corresponding clinical symptoms in three.

DISCUSSION

Methylphenidate, a CNS stimulant, was used in the treatment of tardive dyskinesia in 17 patients, with equivocal results. Six of the subjects showed an increase in symptoms, eight showed no change, and a small number (three subjects) showed some benefit. Such results, scattered across a full range of possibilities, and the inconsistency in the various ratings can be interpreted in several ways. First, the lack of agreement between measures is probably due to the patient's voluntary control over his movements during brief interviews and taping sessions, whereas the global ratings were taken from observations made while the patient was unaware or distracted by routine. Since voluntary modification of their symptoms for five to ten minutes is possible even with severely afflicted patients this would appear to be a likely factor, especially in light of the high reliability of the weekly interview results. This, of course, cannot completely rule out errors of technique but suggests that these were not strong factors.

Second, although the increasing hyperkinesia showed by some of the patients is explained by current knowledge of CNS pharmacology, it had not been so clearly delineated at the time we undertook this project. Moreover, the fact that methylphenidate relieves dystonia produced by acute neuroleptic poisoning but aggravates symptoms of the tardive type suggests differences in the pathophysiology of acute and chronic drug-induced conditions that also fit current theories. Enhancement of striatal dopaminergic mechanisms by methylphenidate should increase choreoathetoid movements as does levodopa in the treatment of Parkinson's disease (23, 24). This supports the observation that another central stimulant, amphetamine, provokes or aggravates dyskinesias (25). Moreover, an increase in psychiatric symptoms in some of the subjects is not surprising since methylphenidate, a CNS stimulant, increases psychomotor activity and thereby evokes bizarre behavior in already disturbed persons (26).

Third, the most plausible explanation for the improvement of functioning in three subjects is that they had a Parkinson-like component (displayed as rigidity and bradykinesia) in their neurological disease that was improved by methylphenidate (27). Serial ratings of these components were not included in this study but in examination before and during treatment these three subjects showed a decrease in these elements, which would suggest such a response to methylphenidate. In some patients parkinsonism and tardive dyskinesia coexist (28) and can be quite difficult to distinguish. This, of course, does not rule out improvement of tardive dyskinesia by methylphenidate, but we consider it unlikely. In any event, since more subjects became symptomatically worse under treatment with methylphenidate (N=6) or showed no change (N=8) than showed improvement (N=3), we conclude that methylphenidate is not effective in improving symptoms of tardive dyskinesia.

Since centrally acting adrenergic and dopaminergic agents improve parkinsonism and augment or provoke hyperkinesia, whereas cholinergic agents relieve some of the choreoathetosis of Huntington's disease (a condition symptomatically similar to tardive dyskinesia) and intensify parkinsonism (29–32), it may follow that tardive dyskinesia results from the weakening of central cholinergic mechanisms and not from the reduction of adrenergic or dopaminergic mechanisms. This suggests that prolonged exposure to the anticholinergic effects of neuroleptics may be responsible for the manifestations of tardive dyskinesia. On the other hand, dopaminergic systems may become hypersensitive under prolonged antagonism by the neuroleptics, either through an effect on receptor sites or an increase in transmitter synthesis. In any event, our rationale for the use of methylphenidate in tardive dskinesia, based on our data on acute neurological side effects, would appear to have been incorrect, although we were encouraged by data from the pilot study. The acute neurotoxic side effects, presumably due to the antagonism of central dopaminergic mechanisms, should therefore respond to a central dopaminergic agonist or cholinergic antagonist (e.g., an anticholinergic agent). Widespread experience shows that agents of

these types are indeed effective in reversing acute drug-induced neurotoxicity.

Phenothiazines, reserpine, and its congener tetrabenazine have been shown to be effective against tardive dyskinesia but it is possible that the use of these drugs involves the same dangers that accompany continued phenothiazine therapy, namely, the continued insult to the affected systems and the possible destruction of central neurons (33). Moreover, treatment with these amine-depleting agents or high doses of phenothiazines results in the substitution of Parkinson-like rigidity for the choreoathetoid manifestations of tardive dyskinesia. Consequently, their use would not be recommended over a long term.

The absence of success in reversing tardive dyskinesia is both discouraging and alarming since it seems that once tardive dyskinesia appears there is no way to reverse it, although Prange and his colleagues have reported preliminary but encouraging results suggesting that tryptophan plus lithium may diminish the movements of tardive dyskinesia (34). The current absence of reliable treatment for tardive dyskinesia suggests great caution in the long-term use of neuroleptics at high dosages.

REFERENCES

1. Ayd FJ: Persistent dyskinesia: a neurologic complication of major tranquilizers. International Drug Therapy Newsletter 1:6, 1966
2. Crane GE: Dyskinesia and neuroleptics. Arch Gen Psychiatry 19:700–703, 1968
3. Crane GE: Tardive dyskinesia in patients treated with major neuroleptics: a review of the literature. Am J Psychiatry 124(Feb suppl): 40–48, 1968
4. Crane GE: Tardive dyskinesia in schizophrenic patients treated with psychotropic drugs. Aggressologie 19:209–218, 1968
5. Crane GE, Paulson G: Involuntary movements in a sample of chronic mental patients and their relation to the treatment with neuroleptics. International Journal of Neuropsychiatry 3:286–291, 1967
6. Crane GE, Ruiz P, Kernohan WJ, et al: Effects of drug withdrawal in tardive dyskinesia. Act Nerv Super 11:30–35, 1969
7. Singer K: Thiopropazate HCl in persistent dyskinesia. Br Med J 4:22–25, 1971
8. Bucci L: The dyskinesias: a new therapeutic approach. Dis Nerv Syst 32:324–328, 1971
9. Siegel JC, Mones RJ: Modification of choreoform activity by haloperidol. JAMA 216:675–676, 1971
10. Kazamatsuri H, Chien C-P, Cole JO: Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine. Am J Psychiatry 130:479–483, 1973
11. Peters HA, Daley RF, Sato S: Reserpine for tardive dyskinesia. N Engl J Med 286:106, 1972
12. Sato S, Daley R, Peters H: Reserpine therapy of phenothiazine-induced dyskinesia. Dis Nerv Syst 32:680–682, 1971
13. Godwin-Austin RB, Clark T: Persistent phenothiazine dyskinesia treated with tetrabenazine. Br Med J 3:25–26, 1971
14. Vale S, Espejel MA: Amantadine for dyskinesia tarda. N Engl J Med 284:673, 1971
15. Crane GE: More on amantadine in tardive dyskinesia. N Engl J Med 285:1150–1151, 1971
16. Crane GE: Failure of pyridoxine in tardive dyskinesia. J Neurol Neurosurg Psychiatry 33:511–512, 1970
17. Klawans, HL: Levodopa in tardive dyskinesia. J Neurol Sci 14:189–192, 1971
18. Kazamatsuri H, Chien C-P, Cole JO: Treatment of tardive dyskinesia, III: clinical efficacy of a dopamine-competing agent, methyldopa. Arch Gen Psychiatry 27:824–827, 1972
19. Fann WE: Use of methylphenidate to counteract the acute dystonic reactions to phenothiazines. Am J Psychiatry 122:1293–1294, 1966
20. Ferguson JT, Funderbark WH: Further evaluation of the new drug methylphenidyl acetate in treating the mentally ill. J Pharmacol Exp Ther 116:20, 1956
21. Natenshon AL: Clinical evaluation of Ritalin. Dis Nerv Syst 17:392–396, 1956
22. Held JM, Cromwell RL, Frank ET, et al: Effect of phenothiazines on reaction time in schizophrenics. J Psychiatr Res 7:39–45, 1970
23. Barbeau A: Importance and pathogenesis of abnormal movements during L-dopa therapy of Parkinson's disease. Neurology 20:377, 1970
24. Papavasiliou PS, Gellene R, Cotzias GC: Modification of parkinsonism: dyskinesias accompanying treatment with dopa, in Psychotropic Drugs and Dysfunctions of the Basal Ganglia, Public Health Service Publication 1938. Edited by Crane G, Gardner R. Washington, DC, US Government Printing Office, 1969, pp 140–147
25. Mattson RH, Calverly JR: Dextroamphetamine-SO_4 induced dyskinesias. JAMA 204:400–402, 1968
26. Janowsky DS, El-Yousef MK, Davis JM, et al: Provocation of schizophrenic symptoms by intravenous administration of methylphenidate. Arch Gen Psychiatry 28:185–191, 1973
27. Holliday AM, Nathan PW: Methylphenidate in parkinsonism. Br Med J 1:1652–1655, 1961
28. Crane G: Motor disorders induced by neuroleptics: a proposed new classification. Arch Gen Psychiatry 24:179–184, 1971
29. Aquilonius JM, Sjostrom R: Cholinergic and dopaminergic mechanisms in Huntington's chorea. Life Sciences 10:405–414, 1971
30. Duvoisin RC: Cholinergic-anticholinergic antagonism in parkinsonism. Arch Neurol 17:124–136, 1967
31. Van Woert MH, Ambaui L, Bowers MB: Levodopa and cholinergic hypersensitivity in Parkinson's disease. Neurology 22:86–93, 1972
32. Klawans HL, Rubovitz R: Central cholinergic-anticholinergic antagonism in Huntington's chorea. Neurology 22:107–116, 1972
33. Christensen E, Moller JE, Faurbye A: Neuropathological investigation of 28 brains from patients with dyskinesia. Acta Psychiatr Scand 46:14–23, 1970
34. Prange AJ Jr, Wilson IC, Morris CE, et al: Preliminary experience with tryptophan and lithium in treatment of tardive dyskinesia. Psychopharmacol Bull 9:36–37, 1973

Management of Tardive Dyskinesia with Thiopropazate

BY JOHN P. CURRAN, M.D.

The author describes the successful management of two severe cases of tardive dyskinesia with thiopropazate. He concludes that the drug does have a place in the management of tardive dyskinesia even though its mechanism of action and long-range effects are unknown. He cautions, however, that it should be used only in severe cases.

IN THE LATE 1950s reports appeared describing a syndrome of allegedly irreversible abnormal motor movements emerging late in the course of phenothiazine treatment. At first the syndrome was called "perioral dyskinesia" because the lower face was frequently involved. However, as it became apparent that muscle groups throughout the body were more commonly affected, and that occasionally the facial musculature was spared, the term "tardive dyskinesia" became more popular (1).

Brain damage and prolonged exposure to phenothiazines were believed from the start to contribute to the development of the syndrome. Recent systematic studies of populations free of brain damage but with high exposure to phenothiazines have helped to clarify the role of the latter (2, 3). One of the more interesting of these findings is the confirmation that the syndrome can be precipitated or aggravated by reducing or discontinuing the administration of phenothiazines (4).

For some time tardive dyskinesia was believed to be untreatable. Recently, however, three reports from England described successful short-term treatment of this syndrome with thiopropazate (Dartal) in doses of 30 to 60 mg. per day (5–7). This drug is a phenothiazine derivative no longer marketed in this country. It is recognized as effective in schizophrenia and is still available in England.

Because of these favorable reports I decided to try thiopropazate when two patients exhibiting severe tardive dyskinesia were hospitalized at Northwestern Hospital, Minneapolis, Minn., for evaluation.

CASE REPORTS

Case 1. The first patient, a 57-year-old woman, was first seen in April 1969. She had a history of a 26-year hospitalization at St. Elizabeths Hospital, Washington, D.C., and was receiving 50 mg. of thiothixene per day. She displayed a thought disorder and a variety of abnormal motor movements: head turning, grinding of the teeth, vertical fluttering movements of both shoulders, and restless limbs. In consultation with her family, it was decided to discontinue the thiothixene and follow her as an outpatient.

In October 1969, she became grossly psychotic, with both hallucinations and delusions. However, the movement disorder was unchanged. Thiothixene was restarted.

In November 1971, the family requested "a new drug" for her. It seemed that the thiothixene was helpful in controlling the psychotic process, but that nothing could be done for the movement disorder, a very distressing sight to behold.

At Northwestern Hospital, after she had been off thiothixene for one week a mental status examination revealed her condition to be basically unchanged from April 1969. There was constant motion of her legs, arms, and torso, along with occasional grimacing. Other patients found her grotesque and socially unacceptable. Because of this and her natural shyness, she spent considerable time in her room.

She was begun on thiopropazate, 5 mg. three times a day, and this dosage was gradually increased to 45 mg. per day over the following ten days. On the fifth treatment day there was an amazing improvement: her writing was much better (before she could barely scribble her signature but now she charted by herself a five-line progress note), she spoke louder and clearer, she was able to embroider, and her neck movements were completely gone, although she would still slowly rock to and fro.

She then slipped considerably from this peak, although her ability to communicate remained undiminished. A second, steady improvement occurred to the extent that by the time of discharge on the 16th treatment day the other patients no longer found her upsetting and socially unacceptable.

One month after discharge her daughter called to report that she was doing remarkably well. The movement disorder was so slight that it was barely noticeable. Moreover, her psychosis was under excellent control.

This patient was afflicted with a severe, socially disabling case of tardive dyskinesia that had been continuously present for at least 32 months before treatment with thiopropazate was initiated. That she improved clinically while on thiopropazate seems indisputable in view of the positive reaction of her peers and her daughter. It is, of course, always possible that what was witnessed was a positive placebo response. I find this rather improbable, however, since there is uniform agreement that the natural history of tardive dyskinesia does not include spontaneous remission.

Case 2. The second patient was a 72-year-old housewife and retired schoolteacher who was first admitted to Northwestern Hospital in January 1971 with a one-year history of presenile dementia confirmed by pneumoencephalography. The only abnormal movement present was a moderate bilateral intention

Dr. Curran is in private practice at 527 Medical Arts Building, 825 Nicollet Mall, Minneapolis, Minn. 55402.

TABLE 1
Summary of Reports on Management of Tardive Dyskinesia with Thiopropazate

Investigator	N	Controls	Length of Treatment	Dosage	Results	Comments
Carruthers (5)	1	None	Unspecified	30–60 mg.	Remarkable improvement	Severe parkinsonism at level of 60 mg.
Singer and Cheng (6)	23	Double-blind placebo crossover	3 weeks	45 mg.	18 improved, 3 unchanged, 2 worse; thiopropazate significantly better than placebo	45 mg./day possibly too high an average dose
Roxburgh (7)	2	Double-blind placebo crossover	3 weeks	30–60 mg.	Considerable improvement in both groups	Temporary unexplained resurgence of low intensity movements at midtreatment

tremor. She was placed on 2 mg. of perphenazine and 25 mg. of amitriptyline three times a day, then on 25 mg. of chlorpromazine four times a day, and was discharged after demonstrating a slight improvement in her memory.

She was readmitted in May 1971 because of weight loss and the observation that she had become "quite jittery." The chlorpromazine was increased to 50 mg. three times a day, then was discontinued abruptly because of drowsiness. Progressive worsening of her "jitteriness" followed. Her movements became so violent that when she was restrained to her bed, the force of her motion moved the bed. Resuming the chlorpromazine after two weeks at a level of 25 mg. three times a day was of questionable help, but after discharge she continued to receive it.

She was readmitted to Northwestern Hospital in December 1971 for evaluation of what had become an uncontrollable movement disorder. This consisted of constant restlessness, with twisting and rolling movements of the trunk, limbs, tongue, and, to a lesser extent, her face. Her legs were flexed and in constant motion, while her lower trunk was rolling and rocking, creating a very grotesque picture, as if she were riding a bike at sea while drunk. There were also occasional protrusions of her tongue. She was diagnosed as having severe progressive dementia plus tardive dyskinesia.

Thiopropazate was begun and increased to a dose of 45 mg. per day over a six-day period. There was a dramatic decrease in her abnormal motor movement. After two weeks of treatment she was much more alert, much more spontaneous, and capable of watching television in perfect control of herself. On the 20th treatment day it was decided to withdraw the medication to see whether her improvement was treatment related. There was a complete return of the movement disorder. The thiopropazate was immediately restarted but this time the response was not marked. Eventually she was discharged to a nursing home in definitely better condition than when she was admitted, since she could walk with support, but she still demonstrated a prominent movement disorder when she was not active. In the nursing home, however, the movement disorder slowly disappeared. On the 77th day she was free of all abnormal movements.

To summarize, this patient, who had documented extensive brain damage, experienced only a trivial exposure to phenothiazines before developing a severe case of tardive dyskinesia, which appeared to accelerate dramatically when even this small dosage was stopped. After seven months she was practically unmanageable. It required ten weeks of treatment with thiopropazate to produce complete remission of the movement disorder. It is, of course, possible that she might have "improved" without any treatment as her brain disease became more widespread and began to involve subcortical nuclei. Yet it is clear that the thiopropazate had a distinct impact on her movement disorder.

DISCUSSION

Until successful management of tardive dyskinesia with thiopropazate was described by several clinicians (table 1), it was thought that the syndrome was irreversible. I did describe three cases precipitated by withdrawing phenothiazines in which partial or total remission was achieved when the phenothiazine in question was restarted (4); however, all three were rather unusual: they were outpatients rather than inpatients and had received only a mild to moderate exposure to phenothiazines, and the tardive dyskinesia had been present only briefly.

I chose 45 mg. per day of thiopropazate as the maximum dosage because of the suggestion (5, 6) that greater doses produced a tendency toward parkinsonism.The results in these two cases, followed for six and ten weeks respectively, support the results of prior but briefer observations. It would seem that thiopropazate does have a place in the management of tardive dyskinesia, although its mechanism of action and long-range effects remain unknown.

Kazamatsuri and his colleagues (8), who also found that thiopropazate has significant antidyskinetic effects, attribute these to its dopamine-blocking properties. However, they briefly reviewed the evidence that tardive dyskinesia itself might be a result of chronic dopamine blockage, and wondered about the ethics and risks of thiopropazate treatment.

In view of these uncertainties, I would recommend that

only severe cases be exposed to thiopropazate, that the minimum therapeutic dose be established as rapidly as possible, and that final judgment be reserved until the results of long-range studies are available.

Also, the experience with patient 2 suggests that phenothiazines should not be used in brain-damaged subjects simply for purposes of sedation. Rather, its use for such patients should be reserved for those cases in which psychosis is definitely present. Simple agitation can be managed with sedatives as such, rather than by relying on the sedating properties of the phenothiazines.

REFERENCES

1. Crane GE: Tardive dyskinesia in patients treated with major neuroleptics: a review of the literature. Am J Psychiatry 124(Feb suppl):40–48, 1968
2. Crane GE, Naranjo ER: Motor disorders induced by neuroleptics, a proposed new classification. Arch Gen Psychiatry 24:179–184, 1971
3. Hershon HI, Kennedy PF, McGuire RJ: Persistence of extrapyramidal disorders and psychiatric relapse after withdrawal of long-term phenothiazine therapy. Br J Psychiatry 120:41–50, 1972
4. Curran JP: Tardive dyskinesia: side effect or not? Am J Psychiatry 130:406–410, 1973
5. Carruthers SC: Persistent tardive dyskinesia. Br Med J 3:572, 1971
6. Singer K, Cheng MN: Thiopropazate hydrochloride in persistent dyskinesia. Br Med J 4:22–25, 1971
7. Roxburgh PA: Treatment of persistent phenothiazine-induced oral dyskinesia. Br J Psychiatry 116:277–280, 1970
8. Kazamatsuri H, Chien C-P, Cole JO: Treatment of tardive dyskinesia, II: short-term efficacy of dopamine-blocking agents haloperidol and thiopropazate. Arch Gen Psychiatry 27:100–103, 1972

Urinary Cyclic AMP in Periodic Catatonia

BY THOMAS L. PERRY, M.D., SUSAN HEMMINGS, GEORGE I. DRUMMOND, PH.D., SHIRLEY HANSEN, AND LEIV R. GJESSING, DR. MED.

Urinary excretion of 3',5'-cyclic adenosine monophosphate (cyclic AMP) was measured in two patients with long-established periodic catatonia. One patient exhibited profound stupor in his psychotic phases, while the other exhibited catatonic excitement. No significant differences in urinary cyclic AMP levels were found in either patient between the interval and psychotic phases, nor were there any significant changes in cyclic AMP excretion at or just before the time of abrupt switch from the interval of normality to catatonic stupor or excitement.

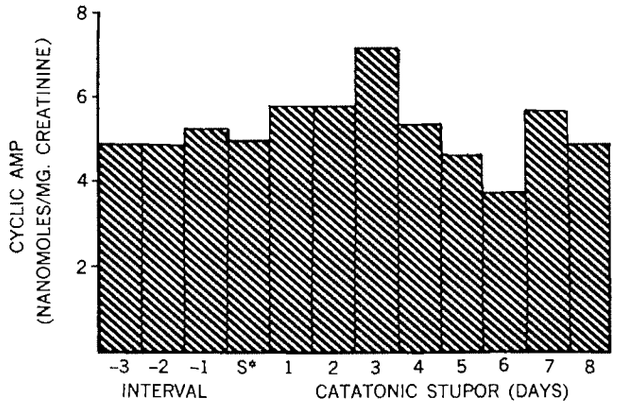
TWO GROUPS OF investigators (1, 2) have reported that the level of urinary excretion of 3',5'-cyclic adenosine monophosphate (cyclic AMP) is lower in patients with psychotic depressions, and higher in patients with mania, than in normal subjects. In patients with manic-depressive psychosis, low levels of urinary cyclic AMP in depression and high levels in mania were observed to change toward normal values when the patients improved (2). A third group of workers (3) found no significant difference in the levels of cyclic AMP in the cerebrospinal fluid of patients with mania, depression, or other neurological disease, and it has been suggested (4) and denied (5) that the increased urinary excretion of cyclic AMP in mania might simply be the result of excessive motor activity. It has also been found that administration of L-dopa to patients with depression caused an increase in urinary cyclic AMP, while administration of lithium carbonate to manic patients resulted in a decrease in urinary cyclic nucleotide (5). Paul and associates (6) observed that, in six patients with manic-depressive psychosis, a sudden increase in urinary cyclic AMP excretion occurred on or just before the day of rapid switch from depression to mania.

We report here studies of urinary cyclic AMP excretion in a different recurrent psychiatric disorder, periodic catatonia. This syndrome was formerly observed in two to three percent of psychotic patients in mental hospitals (7), but since the use of phenothiazines and other tranquilizers has become widespread, it is rarely recognized. The disorder is characterized by regularly recurring episodes of catatonic stupor in some patients and catatonic excitement in others, with interval phases in which the patient's psychic state approaches normal except that he lacks insight into his illness. Character-

Dr. Perry and Dr. Drummond are Professors, Ms. Hemmings is a Research Assistant, and Ms. Hansen is a Research Associate with the Department of Pharmacology, University of British Columbia, Vancouver 8, B.C., Canada. Dr. Gjessing is Chief of the Central Laboratory, Dikemark Sykehus, Asker, Norway.

This work was supported by grants from the Medical Research Council of Canada and the British Columbia Medical Services Foundation.

FIGURE 1
Urinary Cyclic AMP Excretion by Patient E.L. at the End of a Typical Interval Phase and the Early Part of the Ensuing Psychotic Stage



*Day of abrupt shift into catatonic stupor.

istically, the shift from the interval phase to the psychotic phase is dramatic and abrupt, occurring within a single 24-hour period.

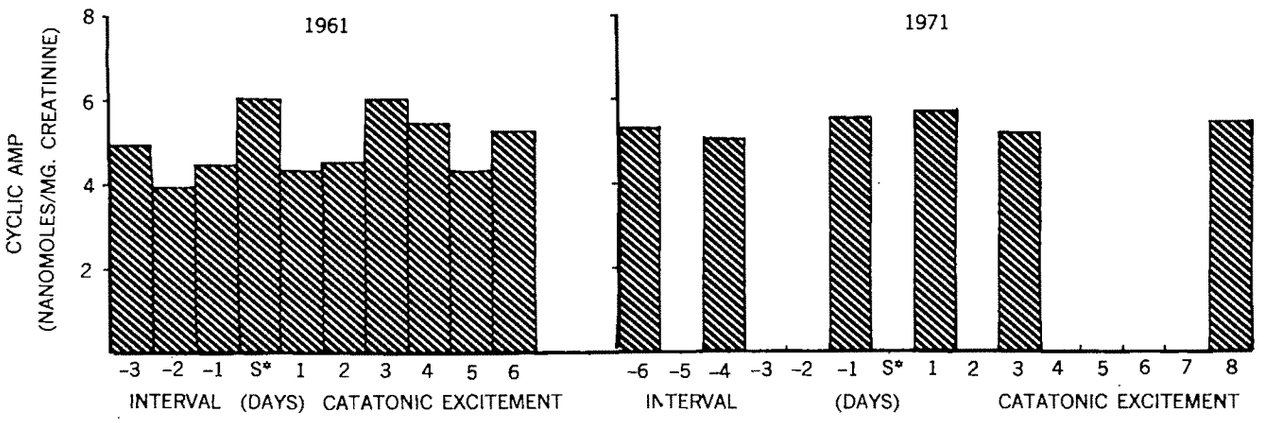
METHOD

The two patients with periodic catatonia we studied have been described previously by Gjessing (8). Urine specimens were collected from one of them (E.L.) in 1965, when he was age 53. At this time he had been having regular periods of profound stupor lasting three or four weeks, separated by intervals of normality of similar duration, for at least 13 years. The second patient (E.R.01), from whom urine specimens were collected both in 1961 (when he was 55) and in 1971 (when he was 65), had for many years suffered recurring psychotic episodes in which he became excited, violent, destructive, and sleepless. These episodes lasted two or three weeks, and were each followed by gradual recovery over several weeks and then by an interval of normality lasting two or three weeks.

First morning urine specimens were collected daily when possible from each patient and were stored frozen at -20C until analyzed. It was not possible to obtain complete 24-hour urine collections from either patient because of the severity of their symptoms during their psychotic phases. Neither patient received any drugs during the periods when urine samples were collected. The specimens from E.L., the patient with recurrent catatonic stupor, were collected while he was being fed a diet limited to milk, cream, eggs, sugar, vitamins, and mineral salts. The specimens collected during 1961 from E.R.01 were obtained while he was maintained on the same limited diet. This diet excluded tea, coffee, and other sources of methyl xanthines (which can act as inhibitors of cyclic AMP phosphodiesterase), as well as all known dietary sources of catecholamines, para-tyramine, and serotonin. However, in 1971 the patient was monitored while on a normal, varied diet; urine samples were not available on a daily basis.

Careful daily records of both patients' mental condition were made by the psychiatric and nursing staffs of the hospital in Norway where these men were cared for, with particular attention to the time of the abrupt shift from the interval of normality to the psychotic phase. Urine specimens representing various points in one or more complete cycles for each patient were coded and shipped frozen in dry ice to Vancouver for assay of the creatinine and cyclic AMP content. These assays were performed by personnel who had not seen the patients and were unaware of their varying mental states. Only

FIGURE 2
Urinary Cyclic AMP Excretion by Patient E.R.01 During the Shifts from Interval Phase to Psychotic Phase in Two Representative Cycles Ten Years Apart



*Day of abrupt shift into catatonic excitement.

when the cyclic AMP determinations had been completed and recorded was the code for the urine specimens broken. This procedure excluded any possible bias in obtaining results.

Cyclic AMP levels were determined by the method of Gilman (9) except that the binding protein was purified from bovine heart rather than skeletal muscle. To ensure the validity of the assay, 20 of the urine samples were also assayed after incubation with 3',5'-cyclic AMP phosphodiesterase (purified from bovine brain), an enzyme that is specific for the nucleoside 3',5'-cyclic phosphate diester bond. The loss of cyclic AMP was apparently complete (95 to 100 percent), indicating that competition for binding was due entirely to the activity of cyclic nucleotide. All assays were performed in duplicate.

RESULTS

The urinary excretion of cyclic AMP by E.L., the patient with catatonic stupor, varied between 3.79 and 7.16 nanomoles/mg. of creatinine when measured on 23 days selected from a single complete cycle of his periodic mental disorder. Urinary cyclic AMP excretion by E.R.01, the patient with periodic catatonic excitement, varied between 3.93 and 6.00 nanomoles/mg. of creatinine during a single complete cycle of his disorder in 1961, and between 3.78 and 6.19 nanomoles/mg. of creatinine during two successive cycles in 1971. The levels of cyclic AMP in the recently voided urine samples of 12 healthy men assayed at the same time and by the same method varied between 2.28 and 4.45 nanomoles/mg. of creatinine (mean = 3.35, standard deviation = 0.71). The reason for the somewhat higher cyclic AMP excretion by the two psychotic patients is not apparent.

No consistent relationship was found between the mental state of either patient and the concentration of cyclic AMP in his urine. Neither did there appear to be anything more than slight random variation in urinary excretion of cyclic AMP on, just before, or immediately after the day of the abrupt onset of the psychotic phases. This is shown in figures 1 and 2. In these figures, the patients' mental state is shown diagrammatically without attempting to grade the severity of the psychotic symptoms, but with an indication of the day of shift from the interval to the psychotic phase.

DISCUSSION

It is not yet known whether the alterations in the urinary excretion of cyclic AMP observed in manic-depressive psychosis (1,2,5,6) reflect important changes in the synthesis or degradation of this cyclic nucleotide in the brain, or whether such changes are primary or merely secondary results of the patients' psychic state. The absence of any significant alteration in the urinary excretion of cyclic AMP around the time of the abrupt shift from the interval phase into either catatonic stupor or excitement does not support the hypothesis that the recurrent psychotic episodes in periodic catatonia are the result of cyclic changes in catecholamine metabolism or release. Despite the negative results of this investigation, longitudinal studies of biochemical factors should certainly be pursued in patients with periodic catatonia whenever they are identified.

REFERENCES

1. Paul MI, Ditzion BR, Janowsky DS: Affective illness and cyclic-AMP excretion. Lancet 1:88, 1970
2. Abdulla YH, Hamadah K: 3',5'Cyclic adenosine monophosphate in depression and mania. Lancet 1:378–381, 1970
3. Robison GA, Coppen AJ, Whybrow PC, et al: Cyclic AMP in affective disorders. Lancet 2:1028–1029, 1970
4. Eccleston D, Loose R, Pullar IA, et al: Exercise and urinary excretion of cyclic AMP. Lancet 2:612–613, 1970
5. Paul MI, Cramer H, Goodwin FK: Urinary cyclic AMP excretion in depression and mania. Arch Gen Psychiatry 24:327–333, 1971
6. Paul MI, Cramer H, Bunney WE Jr: Urinary adenosine 3',5'-monophosphate in the switch process from depression to mania. Science 171:300–303, 1971
7. Gjessing R, Gjessing L: Some main trends in the clinical aspects of periodic catatonia. Acta Psychiatr Scand 37:1–13, 1961
8. Gjessing LR: Studies of periodic catatonia, I: blood levels of protein-bound iodine and urinary excretion of vanillyl-mandelic acid in relation to clinical course. J Psychiatr Res 2:123–134, 1964
9. Gilman AG: A protein binding assay for adenosine 3',5'-cyclic monophosphate. Proc Natl Acad Sci USA 67:305–312, 1970

Collaborative Provision of Aftercare Services

BY ROBERT M. PRINCE, JR., M.D., RAYMOND E. ACKERMAN, M.D., AND BARBARA S. BARKSDALE

Data obtained from mental health clinics and private physicians serving 1,182 chronic psychotic patients demonstrated that group methods not only make more efficient use of manpower but are also significantly more effective than traditional individual methods in the aftercare of these patients. State-level assistance was shown to be quite helpful in improving community-level aftercare programs.

WITH THE DECLINING CENSUS of state mental hospitals, provision of supportive and therapeutic services in the community becomes more important both in maintaining patients after discharge and in preventing rehospitalization. Not only do formerly hospitalized patients make up a significant part of the community psychiatric program clientele, but Kraft and his colleagues (1) have observed a shift in community program populations from patients with neurotic problems to large numbers with schizophrenic diagnoses. At the same time, community program staff members are called upon for consultation and educational services, management of behavior disorders, provision of adequate children's services, and services to lower socioeconomic and other "special" groups. In most areas, the patient in a state mental hospital has traditionally been the responsibility of the state, but upon his return to the community he becomes the community's responsibility. With large and diverse demands for local services, there has necessarily been some resistance to a local program's assuming responsibilities previously held by the state.

Our philosophy has been that community programs which are most successful in meeting high state priorities are developed through state-level leadership, assistance, and support and through cooperative efforts between state and local governments rather than as a result of mandates that are conditions of funding. At the South Carolina Department of Mental Health, we have applied this philosophy by providing consultation to community programs, travel and training funds for community professional staff, and special project funds for programs meeting high state priorities. We recognize that meeting local needs in most instances also meets state needs, but that the priority order is frequently different; consequently we have tended to give our support mainly to those efforts having a relatively high state priority.

We felt that our department put much more emphasis, for example, on adequate aftercare than most community program developers. Our system of community health services is subsidized partly by state and partly by local funds. Local administrative boards have significant authority in determining community priorities and programs. Although there are strong funding influences in program development and although patient aftercare represents a transfer of cost from the state to the community, we felt that the best way to ensure adequate programming was for us to provide significant support and direct services to the local community staff. At the outset, we were uncertain about how to do it. We wanted to avoid the often used approach of "We will provide the advice if you provide the manpower to do the work."

We employed a psychiatrist (R.M.P., Jr.) who had previously been director of a mental health center in our state and had a working knowledge of community attitudes, needs, and problems. Since he was to be working with former hospital patients in the community centers, we felt it important that he also have some contact with the institutional setting. We were able to make an arrangement in which he worked in the aftercare clinic at the South Carolina State Hospital two days a week and in the community services part of his project the remaining three. His job was to identify needs and problems in the provision of aftercare services, to assist the community clinics and centers in developing these services, and to specifically include the direct provision of psychiatric services in the community setting.

When Dr. Prince began his assignment in November 1969 we had no preconceptions about which specific form of aftercare was most appropriate for general application. Community facilities were visited and observations made of programs already in operation. Dr. Prince was particularly impressed with the results of a special Planned Reentry Project (PREP) in Aiken. This project made a concentrated effort to work with chronic patients from Aiken County and produced a dramatic reduction in the state hospital resident population from the county. He was also quite favorably impressed with the efficiency of the aftercare program at the Charleston Area Mental Health Center, where nurses and psychiatrists worked together with groups of ten to 20 patients on a monthly basis.

With these observations, Dr. Prince felt that the lim-

The authors are with the South Carolina Department of Mental Health, where Dr. Prince is Psychiatric Service Chief, Aftercare Project, Division of Community Mental Health Services, P.O. Box 485, Columbia, S.C. 29202; Dr. Ackerman is Deputy Commissioner, Division of Community Mental Health Services; and Ms. Barksdale is Acting Chief, Research and Evaluation Section, Division of Alcohol and Drug Addiction.

ited manpower available could best be used if group methods were incorporated into aftercare. In this way, a special effort could be aimed toward the chronic psychotic patients, the ones most likely to become permanent state hospital residents.

Although the efficiency of group methods is almost universally recognized, the problem of their effectiveness is largely unresolved, as Shattan has observed (2). A research project was therefore devised to test the effectiveness of group methods over a broad area of the state. To do so, Dr. Prince first worked with staff members from seven of the state's 15 mental health facilities, helping each to develop a group aftercare service.

METHOD

The target group for data collection included all patients with a diagnosis of functional psychosis who were released on conditional discharge from the remotivation (chronic) service of the South Carolina State Hospital. Data were collected for patients released during the months of February 1970 through January 1972. Before leaving the hospital, patients from the 22 counties served by this project attended a prerelease group and were given a definite appointment time for a follow-up group in the clinic nearest their home. This was in keeping with the statement of Kimbro and Lemkan (3) that the helping relationship for aftercare patients should be established as soon as the patient gets home or, ideally, even before the patient leaves the hospital.

Patients from the remaining 24 counties were generally given the more traditional individual follow-up treatment, with the majority of these patients seen once a month by a psychiatrist for a brief medication check and supportive psychotherapy. Since patients from all counties were allowed the choice of follow-up by a mental health clinic or a private physician, additional data were collected from the physicians to whom some of these chronic patients were referred.

After patients had passed the one-year anniversary of their discharge, inquiries were sent to mental health clinics and private physicians to determine whether or not the patients had reported for follow-up care, what type of care was given, and how long the patient remained in treatment during the year. Data were retrieved on approximately 90 percent of patients referred to mental health clinics and on approximately 65 percent of those referred to private physicians. State hospital admissions and dispositions sheets provided data on those patients who were returned to the hospital during the year and dates of subsequent releases or returns.

The form of group treatment varied from one clinic to another. The most common approach was a monthly 60- to 90-minute group meeting in which ten to 20 patients were seen jointly by a psychiatrist and a nonmedical staff member. Problems were discussed and ideas shared for approximately an hour, after which prescriptions were written for those patients who needed medication renewal or changes. In several clinics, as groups became too large, a social worker or a nurse would see smaller separate groups, with a psychiatrist available at the end of the group meeting to write prescriptions. These procedures were exceptionally efficient in terms of medical time per patient, since one psychiatrist was responsible for checking medications for up to 30 patients in less than two hours whereas normally he would have scheduled no more than eight patients for individual medication checks during a similar period.

A variant of group follow-up was initiated in two clinics that used mental health association volunteers for a two-hour socialization experience once or twice a month for as many as 30 patients at a time. A psychiatrist was available to write prescriptions, but little was offered to the patients in terms of formal psychotherapy. The attendance at these social groups has been very good, indicating acceptance on the part of the patients and their families. One of these clinics had a separate aftercare therapy group that met once every three weeks in which two social workers served as cotherapists.

Some of the most intensive group follow-up was provided in a rural clinic serving seven counties. An aftercare morning was scheduled twice each month, with volunteers recruited from the local mental health associations and a local college. Transportation was provided to patients who needed it. Patients met as a group for one hour of psychotherapy with two social worker therapists. Immediately following group therapy, several physicians were available to check medications. Volunteers then served refreshments and supervised additional recreational activities, picnics, or field trips.

TABLE 1

Follow-up Data on 1,182 Chronic Psychotic Patients Released on Conditional Discharge: February 1970–January 1972

Method of Treatment	Number of Patients (N=1,182)	Returned During Year (N=475)		In Hospital at End of Year (N=354)	
		N	Percent	N	Percent
Referred to mental health center but never reported	328	161	49	142	43
Referred to mental health center and treated (all methods)	690	253	37	159	23
Referred to private physician but never reported	91	42	46	37	41
Referred to private physician and treated	73	19	26	16	22

RESULTS

As shown by table 1, patients who were treated at a mental health clinic had a significantly lower hospital return rate (37 percent) than those who were referred but

TABLE 2
Breakdown of Mental Health Clinic Treatment Cases

Method of Treatment	Number of Patients (N=690)	Returned During Year (N=253)		In Hospital at End of Year (N=159)	
		N	Percent	N	Percent
Group follow-up, with medication	216	53	25	31	14
Individual medical checks	258	113	44	76	30
Other: intensive psychotherapy, family therapy, or combination	216	87	40	52	24

failed to come for treatment (49 percent). More significantly, only 23 percent of the treated patients were in the hospital on the anniversary of their release on conditional discharge in comparison to 43 percent of the patients who failed to come for aftercare appointments ($\chi^2 = 43.77$; $p < .001$). An additional comparison shows that return rates were lower for patients referred to private physicians than for those referred to public mental health facilities, with resident hospitalization rates not significantly different.

When comparison was made between methods of follow-up, it was found that 14 percent of the patients seen in groups were in the hospital on the anniversary of their release, compared with 30 percent of those who were seen for individual medication checks ($\chi^2 = 15.35$; $p < .001$) and 24 percent of those who were seen in other forms of therapy, including intensive individual therapy, family therapy, or various combinations of therapy (see table 2).

DISCUSSION

Results from this project indicate that group methods are quite practical for the treatment of large numbers of chronic psychotic patients. These methods are not only more efficient but also significantly more effective in this study than the use of individual medication checks.

Group methods help greatly in reducing the feeling of the chronic psychotic patient that he is isolated and uniquely handicapped. Since he has frequently lost almost all social links with his community, as described by Brown (4), the aftercare group helps him reestablish these links. Instead of continuing to feel that there is nobody else in his unusual condition, he is pleasantly surprised to find himself in a group where the room is filled with local people who have similar illnesses. Masnik and her coworkers reported that serving coffee promotes socialization in a subtle way while gratifying the oral dependent strivings of these patients, who are often regressed, isolated, and fearful (5).

Almost invariably, the group patient can receive some encouragement from seeing others with problems similar to his own who are now working or showing definite improvement. If he is bound up in self-pity, he loses some of this when he sees others who are in worse condition than he. He begins to form social acquaintances with other aftercare patients, identifying with the problems of others in the group and receiving gratification through helping others while he is obtaining help for himself. He also becomes impressed with the importance of continuing treatment when he hears some of his fellow patients tell of previous rehospitalization because of having stopped medication or having dropped out of treatment.

It is our opinion that group methods may very well be the preferred treatment for large numbers of chronic psychotic patients, many of whom are now living in their own homes and communities rather than in state institutions. These methods are applicable on a large scale and are exceptionally efficient in terms of professional manpower utilization. Volunteers from local mental health associations, colleges, and other sources can help to provide additional manpower for a very rewarding activity. In addition, much needed social stimulation is provided to patients who have become socially isolated as a consequence of their illness.

REFERENCES

1. Kraft A, Binner P, Dickey B: The community mental health program and the longer stay patient. Arch Gen Psychiatry 6:64–74, 1967
2. Shattan SP: Group treatment of conditionally discharged patients in a mental health clinic. Am J Psychiatry 122:798–805, 1966
3. Kimbro CD, Lemkan PV: Delays in arranging aftercare. Hosp Community Psychiatry 20:91–92, 1969
4. Brown FG: Social linkability. Am J Nurs 71:516–520, 1971
5. Masnik R, Bucci L, Isenberg D, et al: "Coffee and...": a way to treat the untreatable. Am J Psychiatry 128:164–167, 1971

Teenage Helper: A Role in Community Mental Health

BY G.A. ROGENESS, M.D., AND R.A. BEDNAR

To test the effect of being tutors on black, inner-city teenagers, the authors used high school students to tutor fourth- and fifth-grade children who had demonstrated behavior and personality problems in school. Tutoring took place in two schools and a mental health center. The tutors were evaluated on the basis of an interview, a sentence completion test, a questionnaire, and math and reading achievement tests before and after their involvement in the project. While many tutors showed improved achievement scores and most showed changed attitudes toward others, self, education, and the future, the degree of improvement appeared to depend on the structure of the tutoring program.

THE CURRENT SHORTAGE of professional mental health personnel, coupled with a spiraling need for mental health services, has triggered the demand for developing new ways to deliver mental health services. This is especially true of community child psychiatry, where the need is great and the services offered are limited. While nonprofessionals are used increasingly to expand mental health services, few programs use the nonprofessional as both the recipient and the giver of services.

Our study is based on the helper-therapy principle (1), which assumes that providing assistance to persons in need can be at least equally beneficial to the helper. In this study, those in need of assistance were inner-city children who demonstrated behavior and personality problems in their elementary schools. The helpers were high school students from the same immediate community as the grade school children. The children with problems, fourth and fifth graders, were to be helped by the high school students within the context of a tutoring program.

Tutoring of this nature is known to have beneficial effects on the tutees (2, 3) and on the tutor (3), and it is used increasingly as an educational method in many schools (4). The beneficial effects of the helping relationship on the tutor have not been studied adequately nor has the use of the tutor-tutee relationship as an intervention method in community child psychiatry. As a method it has the advantage of being socially relevant and nonstigmatizing, allowing both teenagers and children to participate freely.

This paper focuses on the effect the program has had on the teenagers. The teenage tutors were to provide assistance in solving both academic and emotional problems. Consequently, on the basis of the helper-therapy principle, the program was expected to benefit the tutors by improving them both academically and emotionally.

METHOD

Selection of Tutors

The tutors were black high school teenagers who lived in an inner-city public housing project. They were selected from referrals made by people and agencies working in the community and from teenagers who answered advertisements posted in the local high schools. They were hired on a "first come, first served" basis after an initial interview with the project director, a psychiatrist. Two applicants were rejected on the basis of the initial interview; one was judged to be a borderline psychotic, and the other was judged to be unable to work satisfactorily with children. A total of 11 boys and 14 girls were hired and were paid $1.60 per hour for ten hours of work per week. Most of the teenagers hired were sophomores or juniors in high school.

Evaluation

The evaluation of the tutors consisted of the interview with the director, a sentence completion test, a questionnaire, and the Science Research Associates' achievement series tests in reading and math. All measures except the interview were given in a group. The teenagers were told that the tests were necessary to evaluate the program. The tests were given before the start and again three weeks before the end of the program. Approximately seven months elapsed between the test and retest dates.

Each tutor's responses on the sentence completion test (64 sentences) and the questionnaire (28 items) were independently rated for change by two judges. A tutor's response was recorded as changed only when both judges reported a change in the response. Interjudge agreement on change in the responses was .74.

Dr. Rogeness and Mr. Bednar are both with the Katharine Wright Psychiatric Clinic, 923 West Wellington Ave., Chicago, Ill. 60657, where Dr. Rogeness is Child Psychiatrist and Mr. Bednar is Psychologist. Dr. Rogeness is also Instructor, Department of Psychiatry, Abraham Lincoln School of Medicine, University of Illinois Medical Center, and Child Fellow, Institute for Juvenile Research, Chicago.

This project was supported by funds from the W. Clement and Jessie V. Stone Foundation, the Chicago Community Trust, the University of Illinois Foundation, the Norman Foundation, and the Neighborhood Youth Corps.

The authors wish to thank Sherman Carter, Director, Lower North Mental Health Center, and Roger White, Coordinator of Program Development, Neighborhood Youth Corps, for their active support, and Dr. Melvin Sabshin and Dr. Herman Diesenhaus of the University of Illinois for their helpful consultation.

TABLE 1
Tutoring Group Means for Reading and Math Scores at the Start and End of the Tutoring Program*

Subject	Group		
	A (N=6)	B (N=4)	MHC (N=5)
Arithmetic			
Pretest	5.88	6.02	8.10
Posttest	6.16	6.22	9.45
Reading comprehension			
Pretest	4.51	6.55	7.70
Posttest	6.45	6.82	7.16
Reading vocabulary			
Pretest	5.16	6.75	7.62
Posttest	8.16	6.47	7.74
Reading total			
Pretest	4.90	6.70	7.64
Posttest	7.50	6.65	7.44

*Means are given in terms of grade level.

Procedure

The 25 tutors were divided into two groups of ten tutors each and one group of five tutors. Each group was assigned to a different location and tutoring situation. One group of ten tutors (A), four boys and six girls, was assigned to school A; a second group, with five tutors (B), two boys and three girls, was assigned to school B; and the third group, with ten (MHC), five girls and five boys, was assigned to a mental health center. The tutoring at the elementary schools took place during school hours; the children were called out of their classrooms twice a week to work with their tutors. The tutoring at the mental health center occurred after school hours between 4:30 and 6:30 p.m.

Eighty children from school A and 20 children from school B took part in the program. Forty children from school A were tutored during school hours, and the remaining 40 children were tutored after school at the mental health center. Each group of tutees consisted of an equal number of boys and girls and an equal number of fourth and fifth graders. The tutees were selected (5) on the basis of their personality and behavior severity scores on a modified version of the Peterson's behavior problem checklist. Each tutor was randomly assigned four children from either fourth or fifth grade and usually of the same sex as the tutor. The children were tutored twice a week in one-hour sessions. Each tutor saw two children per day for four days and met with the other tutors in his group for a two-hour discussion session on the fifth day.

One mental health worker was assigned to supervise a group of five tutors. The supervisors were responsible for structuring the tutoring sessions for their group, selecting tutoring materials, recording attendance, administering tests, and leading group discussions. The supervisors were told that the aim of the program was to improve the reading and math abilities, the behavior, and the emotional adjustment of the grade school children. They were asked to structure a program for their tutors that would emphasize reading and math tutoring and personal counseling of the tutees. The group discussion for the tutors was to be a forum for developing and fostering the attitudes and techniques necessary for accomplishing the goals of the program.

Because the supervisors were free to develop and structure their own program, each group had a distinctly different tutoring method. Of the three groups, the A group had the most highly structured program. This group spent at least 30 minutes of each hour tutoring in math and/or reading and the remainder of the hour in game playing, informal discussion, or personal counseling. For tutoring materials they used a variety of reading materials, the Science Research Associates' *Reading Laboratory Program*, and mimeographed mathematics and vocabulary worksheets.

The emphasis in the A group was on tutoring in reading and changing disruptive behaviors. Their group discussions explored the importance of education and the value of cooperation, tolerance, and understanding between people. All tutoring for the majority of the year took place in a large meeting room with separate work tables for each tutor-tutee pair.

The B group also tutored in one large room at separate desks. This group encouraged the child's teacher to assign work for the tutoring sessions. When the teacher-assigned work was completed, the tutors were allowed to select their own materials with the supervisor's help. Tutors in the B group emphasized math and also preferred word games. The tutoring group's weekly discussion sessions were group-centered and -directed with no particular emphasis.

The MHC group tutored in individual rooms and was the least structured of the three groups. Tutors in this group were free to structure their own tutoring sessions. The materials available to them were basically the same as those available to the A group. The emphasis in this tutoring group was on math instruction with a moderate emphasis on word games. The tutors were encouraged to engage in informal discussion and counseling with their tutees. The tutors' group discussion session was group-directed and tended to emphasize discussions of community and family problems.

RESULTS

Attendance

Complete attendance records were kept for the A group only. These indicated that the average attendance rate for the teenagers was 80.5 percent. The MHC and B group supervisors estimated that attendance rates for their groups were at least as high. Four tutors, one each from groups A and B and two from group MHC, were dropped from the program because of poor attendance.

Achievement Scores

The tutoring group means for reading and math

achievement scores are presented in table 1.[1] At the start of the program all tutors were below grade level in reading and math ability; the average tutor was reading and doing math at a sixth-grade level.

The analysis of variance of the math achievement scores produced significant main effects of test time ($p < .10$) and group ($p < .05$). The MHC group was significantly better in math ability than either of the other two groups. The program resulted in a significant improvement in the tutors' math ability, with the MHC group gaining an average of 1.35 years in seven months' time. Boys tended to show greater improvement in math ability than did girls.

The analysis of variance of both the reading vocabulary and total reading achievement scores produced significant main effects of test time and group-by-test-time interactions. On both variables, the A group improved significantly during the program while the other two groups remained relatively unchanged. The A group improved an average of 3.0 years in reading vocabulary and 2.6 years in total reading ability. Again, boys tended to show greater improvement than girls.

Sentence Completion Test

A comparison of the sentence completion pretest and posttest data showed changes in four main areas. These areas are relations with others and attitudes toward the self, education, and the future. Table 2 presents the sentence completion results in terms of the number of tutors initially expressing and shifting an attitude. All percentages reported below indicate the percentage of tutors expressing a change in attitude after tutoring, compared with their initial feeling.

Eighty-one percent of the teenagers became more concerned about and put greater emphasis on their relationships with others. They became more positive about their heterosexual relations (43 percent); however, they expressed more hostility and negative feelings toward the generalized other (33 percent). Fifty-two percent of the teenagers became more introspective and showed more self-awareness. The teenagers exhibited more self-esteem (57 percent), more self-confidence (33 percent), and more self-concern (33 percent). They reported an increased concern over injustices to themselves and to others (29 percent) and placed greater emphasis on understanding themselves and others (29 percent).

The tutors tended to become more concerned about the future (48 percent). Thirty-three percent looked more optimistically toward the future, while five percent were more pessimistic about the future.

Almost half of the group (48 percent) placed more emphasis on the value of education. This emphasis did not indicate a parallel concern over schoolwork. Only 29 percent of the teenagers became more concerned about their schoolwork.

TABLE 2

Tutor Attitudes That Showed Sizable Changes on the Sentence Completion Test (N=21)

Attitude	Before Tutoring*	Greater After Tutoring**	No Change After Tutoring***
Is concerned about relations with others	6	17	0
Positive about heterosexual relations	10	9	6
Negative about heterosexual relations	4	2	0
Positive feelings toward others	6	3	2
Negative feelings toward others	1	7	1
Introspective and self-aware	5	11	1
Has self-esteem	0	12	0
Has self-confidence	3	7	3
Has self-concern	1	7	0
Is concerned over injustices	1	6	1
Wants to understand self and others	7	6	1
Is future oriented	9	10	2
Optimistic about future	7	7	2
Pessimistic about future	4	1	0
Values education	12	10	1
Values own schoolwork	9	6	2
Is critical of others	0	6	0
Suspicious and distrustful	1	5	1
Positive feelings toward friends	10	2	5
Negative feelings toward friends	4	2	0

*Number of tutors expressing the attitude before the tutoring program.
**Number of tutors expressing a change in attitude (new interest or greater interest) after tutoring, compared with their initial feeling.
***Number of tutors initially expressing an attitude and showing no change after tutoring.

In addition to these general findings, each group seemed to differ in their areas of change. The A group expressed more self-confidence, more concern over injustices, and more optimism toward the future than the other two groups. The B group became more critical of others, more suspicious and distrustful, and were peculiar in not placing any emphasis on the value of education or a concern over schoolwork. The MHC group placed greater emphasis on the value of education and became more self-concerned, introspective, and hostile and negative toward friends.

Questionnaire

The questionnaire was a less structured device than the sentence completion measure. The analysis of these data reveals that the tutors' attitudes changed in three main ways: toward others, self, and the future.

Interview

The interview data tended to indicate changes that

[1] The achievement tests were administered and scored by an independent testing service. Not all of the tutors were processed for employment when the tests were originally scheduled and rescheduling of the tests proved to be difficult. Consequently only 15 of the 25 tutors took the tests both before and after the tutoring program.

were more specific to the individual. The general trends that emerged were an increased concern for others and the needs of others (59 percent); an increased openness, i.e., the tutors were more willing to give their opinions and beliefs (47 percent); and an increased emphasis on the importance of being patient and understanding in the tutoring relationship (41 percent). These general trends were most evident in the A group.

DISCUSSION

The results indicate that teenagers' achievement levels can improve as a result of tutoring; the increase in achievement, however, seems to be dependent on the structure of the tutoring program. The increase in achievement may also be related to changes in the attitudes of the teenagers. For example, group A, judged to have made the greatest improvement in openness and personal adjustment on the basis of the psychiatric interview, made the greatest academic progress.

The data indicate that some of the attitudes of the teenagers changed during the program. The most prominent and consistent changes were in attitudes toward others, toward the self, toward education, and toward the future. The change in attitudes and the direction of change appear to be determined by: 1) being the helper, 2) the quality of supervision, and 3) the weekly group meetings. The teenagers actually did help the tutees by producing beneficial academic and behavioral changes. While this helping role seems to provide the vehicle for attitude change in the tutors, it does not seem to be sufficient in itself. A supervisor who is supportive and helpful to the tutor and a group meeting that focuses on concern for others, for self, for how one's behavior affects others, and on the value of education also seem to be necessary. Of prime importance was the fact that tutoring was socially acceptable to the teenagers and gave them an active and responsible role in the change process.

Certainly the teenage helper has a role in community mental health. This program enabled us to work with a large group of teenagers who were in a high-risk group for truancy, dropping out of school, delinquency, and illegitimacy. The role of helper is socially valued, whereas the role of patient carries a social stigma.

The majority of teenagers living in disadvantaged areas who are referred as patients do not continue in treatment for any length of time and frequently do not even show up for the initial visit. Those who do continue are often the most disturbed, which helps to maintain the unfortunate belief that mental health centers are only for people who are crazy. Tutoring is a vehicle for working with teenagers that incorporates the beneficial side effect of helping to change many people's concept of a mental health center.

REFERENCES

1. Riessman F: The helper-therapy principle. Social Work 10:27–65, 1965
2. Arthur G: Tutoring as Therapy. New York, The Commonwealth Fund, 1946
3. Cloward R: Studies in tutoring. Journal of Experimental Education 36:14–25, 1967
4. Thelen H: Tutoring by students. School Review 77:229–244, 1969
5. Rogeness GA, Bednar RA: A mental health treatment and prevention program for children using teenage tutors, 1971 (unpublished)

LETTERS TO THE EDITOR

Imipramine in Hyperacusic Depression

SIR: Identical psychiatric syndromes may have a variety of biologic or environmental etiologies, each with its respective optimal therapy. A common clinical predicament is to decide, on the basis of a dreadfully inadequate nosology, how most expeditiously to alleviate severe depression. Valuable time (in terms of suicide risk, hospitalization expense, and personal suffering) may be lost in a fruitless trial of one medication before an alternate modality is decided upon.

Combination therapies represent one solution to this dilemma, e.g., tricyclics and either ECT, monoamine oxidase (MAO) inhibitors, or amphetamines; or a combination of a predominantly indoleaminergic tertiary-amine tricyclic (e.g., imipramine) and a catecholeaminergic secondary tricyclic (e.g., desipramine). But this sort of "shotgun" therapy often compounds liabilities as well as benefits. A more effective approach might be to select physiologic concomitants of specific neurochemical lesions and, to the extent that the former are exhibited by the individual patient, to direct therapy toward his hypothesized chemical needs.

Central serotoninergic hypoactivity has been proposed as a critical defect in at least some severe depressives. Hyperacusia is a not uncommon symptom of such patients, bearing no apparent relation to polarity of depression in the population studied. In rodents, depletion of brain serotonin by parachlorophenylalanine (1) or serotoninergic blockade by methysergide (2) create an animal equivalent of hyperacusia, increasing the magnitude of auditory startle response and retarding habituation to auditory startle stimuli. Thus one might predict that hyperacusic depressives would be most likely to respond to a predominantly pro-indole modality such as imipramine or L-tryptophan.

Seven patients hospitalized for primary depression reported that when depressed they were more bothered by routine noises in their homes and places of work and that sounds which they had previously ignored became annoying distractions, intruding on their attempts to concentrate or go to sleep. Seven other patients, matched with the first seven for age, sex, and severity of depression, were chosen from a larger group that denied such auditory disturbances.

After ten days on an identical dosage schedule of imipramine, six of the hyperacusic group had begun to demonstrate objective signs and to report subjective symptoms of mood improvement. Only two of the auditory-normal group had so responded. After three weeks, all of the first but only four of the second group had responded. The remaining three auditory-normals required adjunctive or alternative therapies.

These results suggest the validity of extrapolation from animal pharmacology and its considerable value in "custom-tailoring" pharmacotherapy to the individual patient with affective illness.

REFERENCES

1. Conner RL, Stolk JM, Barchas JD, et al: Parachlorophenylalanine and habituation to repetitive auditory startle stimuli in rats. Physiol Behav 5:1215–1219, 1970
2. Carman JS, Prange AJ: unpublished data, 1971

JOHN SCOTT CARMAN, M.D.
Chapel Hill, N.C.

Suicide and the Psychiatrist

SIR: Suicide is committed by psychiatrists somewhat more often than by physicians generally. Physicians commit suicide at about the same rate as other men. From some quarters we now hear, "Psychiatrist, heal thyself." The American Psychiatric Association has created a Task Force on Suicide to study suicide by physicians, with particular attention to psychiatrists, in greater depth.

Any study as complex as this must be multifaceted. Epidemiologic approaches are fairly straightforward and the task force will not ask for the cooperation of the membership of the Association for such studies. However, the detailed case history approach, which has been so useful to us in our everyday practice, will require the cooperation of some of the membership since we are looking at our own colleagues.

We know that the same factors important in suicide generally apply to suicide by psychiatrists—for example, alcohol and drug problems and multiple losses of love, health, and image—but we do not know enough of the specifics.

Some theories that have been advanced to account for the higher rate of suicide by psychiatrists include: 1) people who go into psychiatry are disturbed to begin with; 2) psychiatrists suffer from a high rate of manic-depressive illness; 3) psychiatrists think about suicide because they are around suicidal people all the time; 4) psychiatrists drink too much or have unstable marriages; 5) psychiatrists are too proud—they have nobody with whom to talk about themselves.

To help us study this problem we request that any member of the Association who is aware of the suicide of a psychiatrist (including psychiatric residents) and who can suggest leads by which we can discretely study the preceding circumstances inform the task force of the event. The task force will then get in touch with the member to pursue the matter in depth.

Letters may be addressed to the Task Force on Suicide Prevention, American Psychiatric Association, 333 Commonwealth Ave., Chestnut Hill, Mass. 02167.

MATHEW ROSS, M.D
Chairman, Task Force on Suicide Prevention
Chestnut Hill, Mass.

Emotional Involvement in Psychotherapy

SIR: The editorial "Group Psychotherapy in Perspective" by

Dr. Hyman Spotnitz (November 1972 issue) calls for some comment from a psychoanalyst. He suggests that analysts do not have emotions in relation to their patients' treatment. He states, "Rigid adherence to the notion of countertransference as an invariable source of resistance . . . retarded the development of an effective psychotherapy."

The analyst having feelings about his patients is something far different from the "notion of countertransference." Dr. Spotnitz goes on to slur Freud and psychoanalysts by implying that they are therapists who are so troubled by their own feelings and by any feelings stirred up by their patients that they must hide behind "the self-defensive rigidity of the classical method." He then goes on to suggest that enlightened group psychotherapists have advanced to the preferred state of having discovered that feelings for one's patients facilitate treatment. But then he adds, ". . . provided that the practitioner's behavior is consistently oriented to resolving the obstacles to emotional maturity that emerge in each case."

Dr. Spotnitz apparently has little understanding of what the psychoanalyst does and what the theoretical basis for his work is. I might suggest the reading of a paper by Edward Bibring (1). The notion that analysts do not experience feelings, or that they do not allow feelings to be experienced either by themselves or their patients, is false. The matter of the analyst's neutrality can only come into play after he is quite aware of what feelings are stirred up. Dr. Spotnitz' comment that the therapist's behavior should be "consistently oriented to resolving the obstacles to emotional maturity" states the psychoanalytic position quite well. The concept of countertransference is not, as Dr. Spotnitz implies, a wall that the analyst hides behind, but a way of understanding certain emotional obstacles to emotional maturity that consistently crop up in the course of every psychological treatment.

That Dr. Spotnitz is perplexed by the problem of the aroused emotions of his patients seems evident when he goes on to point out that group therapy is an "exceptionally powerful vehicle for arousing emotions, and how to exploit this force without exposing patients to damaging action is still an unsolved problem." But here again he is wrong. It is exactly these powerful emotions which are the driving force behind all successful therapies, including psychoanalysis. The concept of transference, properly understood and tactfully used, has "solved" the problem. (Transference is the unconscious and inappropriate repetition during treatment of emotional experiences that were once experienced in relation to some important person out of the past [2].)

What appears to Dr. Spotnitz as the analyst's unwillingness to get involved with the patient's emotional catharsis is really exactly the opposite. The analyst is most intensely involved in the patient's emotions, but he does not permit the acting out of these emotions by either the patient or himself. Analysis aims to convert the patient's insatiable unconscious need to reexperience feelings into a conscious understanding of the conflicts that give rise to this need. Only then can the patient be cured, i.e., have the relative ability to choose what he wants to experience rather than being driven to act and feel by unconscious conflictual forces.

The major problem that the group therapies face is, according to Dr. Spotnitz, the difficulty of getting patients to vent their feelings without promoting damaging actions. This may be so, but he is wrong if he thinks that group therapy represents an advance in therapeutic technique by getting us back to the "disorganizing embroilments with patients." He is crassly ignorant of the facts when he states that Freud "solved the problem . . . by eliminating the analyst's emotions as a factor in treatment." Kohut (3) has written on the important tools of empathy and introspection in psychoanalysis. Freud's extensive writings on the subject of transference and countertransference throughout his lifetime are evidence enough that he never stopped thinking about and reworking the whole complex matter of emotional reactions in psychoanalysis (4, pp. 112–122; 5–7).

The essential distinction between individual psychotherapy (including psychoanalysis) and the group therapies exists not in the absence or presence of emotional involvements, since these clearly exist in both, but rather in the fact that the emotional involvements (transference-countertransference) become much more diffuse in the group setting.

REFERENCES

1. Bibring E: Psychoanalysis and the dynamic psychotherapies. J Am Psychoanal Assoc 2:745–770, 1954
2. Greenson RR: The Technique and Practice of Psychoanalysis. New York, International Universities Press, 1967
3. Kohut H: Introspection, empathy and psychoanalysis: an examination of the relationship between mode of observation and theory. J Am Psychoanal Assoc 7:459–483, 1959
4. Freud S: Fragment of an analysis in a case of hysteria (1905), in Complete Psychological Works, standard ed, vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 7–122
5. Freud S: The dynamics of transference (1912). Ibid, vol 12, pp 97–108
6. Freud S: Introductory lectures on psycho-analysis (1916–1917): transference (27), analytic therapy (28). Ibid, vol 16, pp 431–463
7. Freud S: Analysis terminable and interminable (1937). Ibid, vol 23, pp 209–253

DANIEL B. GESENWAY, M.D.
Philadelphia, Pa.

Dr. Spotnitz Replies

SIR: In stating that I have suggested that "analysts do not have emotions in relation to their patients' treatment" and that my editorial slurs Freud and psychoanalysts, Dr. Gesenway grossly misinterprets my observation on the profound influence that Freud's recommendations on technique exerted on the methodology of classical psychoanalysis. This view is amply documented, for one example, by his warning in 1915 against "any tendency to a counter-transference" (1, p. 160) and his statement in 1912: "I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, *who puts aside his feelings, even his human sympathy* [emphasis added], and concentrates his mental forces on the single aim of performing the operation as skilfully as possible. . . . The justification for requiring this *emotional coldness* [emphasis added] in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help that we can give him to-day" (2, p. 115).

Freud later modified this position; for instance, in a personal communication, written in 1913 but published posthumously (3, p. 50), he even advocated the controlled use of positive feelings for patients. (He did not reach the point of recommending the controlled use of negative feelings.) However, the formulations that figured significantly in the history of the psychoanalytic method served to retard the development of an effective psychotherapy for schizophrenic patients and others with pre-oedipal problems. Explanations of transference resistance (interpretation), the major factor in the classical method, are frequently ineffectual and sometimes antitherapeutic for such

patients. Freud, of course, did not attempt to develop a method for working with these patients, but today we are concerned with that task, and my remarks were made in that context.

Writing in a doctrinaire manner that is inconsistent with the spirit of scientific psychotherapy advocated by Freud, Dr. Gesenway raises specific points that space limitations do not permit me to answer here. But I would assure him that I agree with him that analysts have different types of feelings in relation to their patients. I have in fact focused on this subject in my book on the theory of psychoanalytic technique in schizophrenia (4) and in an earlier publication (5). I have distinguished between the types of feelings of the practitioner whose expression are usually contraindicated and those whose use in a controlled way provide him with therapeutic leverage.

Illustrative of Dr. Gesenway's tendency to be dogmatic and indulge in incorrect generalizations is the statement that "emotional involvements (transference-countertransference) become much more diffuse in the group setting." This observation is not generally applicable; the involvements may indeed become more concentrated. Some patients develop an intense excitement in the group setting not only for the other participants individually but also for the group as a whole. That is one of the important reasons why therapists commonly demonstrate reluctance to treat potentially psychotic patients in the group setting. Some of these patients can be helped with less emotional involvement in the dyad, where the danger of precipitating a psychotic episode is not so great.

Dr. Gesenway appears to favor emotional neutrality in the analyst. I agree that the analyst should be capable of emotional objectivity, but I advocate consistent analysis by the practitioner of the full range of his emotions, to determine their significance and the precise emotional responsiveness that will meet the patient's maturational needs.

REFERENCES

1. Freud S: Observations on transference-love (1915), in Complete Psychological Works, standard ed, vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 157–171
2. Freud S: Recommendations to physicians practising psychoanalysis (1912). Ibid, pp 109–120
3. Binswanger L: Sigmund Freud: Reminiscence of a Friendship. New York, Grune & Stratton, 1957
4. Spotnitz H: Modern Psychoanalysis of the Schizophrenic Patient: Theory of a Technique. New York, Grune & Stratton, 1969
5. Spotnitz H: The toxoid response. Psychoanal Rev 50:612–624, 1963–1964

HYMAN SPOTNITZ, M.D.
New York, N.Y.

Drug Comparison in Hyperactive Children

SIR: The paper titled "Effects of Dextroamphetamine, Chlorpromazine, and Hydroxyzine on Behavior and Performance in Hyperactive Children" by Drs. Greenberg, Deem, and McMahon (November 1972 issue) has some serious flaws that we feel merit comment. The authors present at least 19 outcome measures divided into four major categories. Chlorpromazine showed significant improvement on only one measure. Significant results on one out of 19 measures is hardly better than expected by chance for independent scales. Indeed, even success in one out of four categories is not unlikely when the significance level is only .05. In contrast, dextroamphetamine showed significant results on five measures covering three of the categories and marginally significant results on two additional measures. For dextroamphetamine, then, significant or marginally significant results were obtained in all four categories. Particularly striking was the positive effect dextroamphetamine showed on measures of intellectual performance. Chlorpromazine showed no similar effect. In fact, although it is generally felt that chlorpromazine effectively reduces hyperactivity, the data presented in this paper leave some doubt that this drug had any beneficial effect. Certainly the summary is misleading in noting only the limited positive result for chlorpromazine.

A more serious flaw exists, perhaps, in the doses and dose schedules used in this study. The average daily dose of dextroamphetamine during the primary evaluation period was 25 mg., approximately twice the average therapeutic dose of this drug prescribed by physicians for hyperactivity in children. In addition, the authors prescribed an after-school dose of dextroamphetamine, a practice not generally advised with stimulants. This 4 p.m. dose probably averaged 5 to 10 mg., a dose of dextroamphetamine guaranteed to cause a high level of insomnia and subsequent irritability. Similarly, but to a less marked degree, the morning dose of chlorpromazine—75 mg.—is a good deal higher than that usually given at that hour in equivalent tablet form and would be expected to cause a good deal of drowsiness. Thus the type and number of side effects reported in the paper were in large measure attributable to the large drug doses and the peculiar dose schedules employed. The comparisons of drug side effects and outcome results from the data are, accordingly, of limited clinical significance.

The paper presents some interesting data, but its conclusion that chlorpromazine and dextroamphetamine are of equivalent value in the treatment of hyperactive children is not supported. In future studies, we suggest that the authors employ a single (morning) daily dose schedule of stimulant medication. We think that they will find, as we did with methylphenidate (20 to 40 mg. administered each morning), that side effects with this dose schedule are few and that clinical results are as impressive as they are with the usual morning and noon dose schedule.

DANIEL J. SAFER, M.D.
RICHARD P. ALLEN, PH.D.
Baltimore, Md.

Drs. Greenberg, Deem, and McMahon Reply

SIR: Drs. Safer and Allen have identified two critical problems in pharmacotherapy research: the selection of medication administration variables and the selection of outcome criteria.

Dosage level is, of course, a critical variable in treatment studies. Unfortunately the literature is full of contradictory advice to the prescribing clinician (1). We are not aware of the data from which one can conclude that 25 mg. of dextroamphetamine is "approximately twice the average therapeutic dose prescribed by physicians." We must caution against the implicit assumption that there is necessarily a relationship between the clinician's average dosage level and an optimal dosage level, particularly when acceptably reliable and valid criteria of improvement are lacking. In our study, the prescribing pediatrician varied the medication as clinically indicated for each child. The children were examined more frequently than would be expected in the usual clinical practice and for a longer period of time than reported by most of the other research groups. Utilizing a flexible administration schedule and this particular sample of children, 25 mg. of dextroamphetamine was the mean dosage level. Recognizing that it is difficult, if not

impossible, to impose a realistic, standardized means of determining when side effects outweigh the probability of further behavioral improvement, we relied upon the pediatrician's clinical judgment.

The time of medication administration was another critical consideration. All four medications were administered twice each day at the same times (7 a.m. and 2 p.m.), although amphetamines are generally given morning and noon while chlorpromazine is given morning and evening. However, a uniform schedule was necessary to reduce clues available to the clinical judges and to adequately treat the presenting symptom, hyperactivity, which was present not only during school hours but also throughout the day. From our data, we concluded that when a clinically acceptable result (i.e., reduction in daytime hyperactivity) was obtained, there were many serious side effects with dextroamphetamine. Chlorpromazine, on the other hand, did not appear to reduce performance scores as might be expected and was not associated with any serious side effects. It was emphasized that the incidence of side effects as well as the clinical benefits must be taken into account when one prescribes the medications studied.

We cannot comment from the present study about the relative merits of methylphenidate versus dextroamphetamine, but we do recognize the need for a carefully documented comparison. It does appear, however, that Drs. Safer and Allen recommend a dosage range for methylphenidate that is roughly equivalent to our final dosage range for dextroamphetamine, assuming that the former is approximately half as potent as the latter drug.

The selection of outcome criteria is an issue that cannot be adequately covered in the few sentences available for a response. We agree with Drs. Safer and Allen that dextroamphetamine was associated with significant improvements on a number of performance scores whereas chlorpromazine was not. However, the clinical significance of these differences is not clear. While the beneficial effects of dextroamphetamine on IQ scores cannot be ignored, it cannot be assumed that higher IQ scores indicate desirable clinical (i.e., behavioral) changes. Indeed, we do not know if higher testing scores even indicate improvement in academic achievement. In this study, reduction in hyperactivity, as indicated in behavioral ratings by the prescribing clinician and the family, was selected as the primary index of improvement. Other indices of change were mentioned in the report and must also be considered. The question is complex: What constitute acceptable, meaningful criteria for drug treatment outcome? Unfortunately, it remains unanswered.

Recognizing the legitimacy of Drs. Safer and Allen's remarks, the data presented in our paper appear to support the following conclusions: 1) chlorpromazine and dextroamphetamine were equally effective in modifying hyperactivity as measured by behavior inventories; 2) dextroamphetamine produced more frequent and serious side effects than did chlorpromazine; and 3) dextroamphetamine was associated with improved functioning on selected performance tests that were not affected by chlorpromazine.

We agree with Drs. Safer and Allen that there are many serious methodological problems in the present study and in current pharmacotherapy research (2). It is very important that clinicians recognize the limitations in research design and interpret the recommendations accordingly.

REFERENCES

1. McMahon S, Deem M, Greenberg L: The hyperactive child. Clin Proc Child Hosp DC 26:295–316, 1970

2. Fish B: Methodology in child psychopharmacology, in Psychopharmacology: A Review of Progress 1957–1967. Edited by Efron D. Public Health Service Publication 1836. Washington, DC, US Government Printing Office, 1968, pp 989–1002

L. M. GREENBERG, M.D.
M. A. DEEM, PH.D.
S. MCMAHON, M.D.
Davis, Calif.

Sensitivity Reaction to Imipramine

SIR: During the past six and a half years imipramine has been used with uniformly excellent results at the Sinnissippi Mental Health Center—a rural community mental health center in Illinois—as the treatment of choice for hyperkinetic children. In our experience with several hundred children a curious side effect has been observed in both the clinical setting and in a learning disabilities class setting in the public schools in approximately one to three percent of the children on this medication.

As far as we know, no one has reported the clinical observation of a small percentage of children (approximately three out of 100) becoming psychologically sensitive while taking imipramine. The reported and observed symptomatology is a sudden onset of tearfulness, verbalizations of guilt feelings (usually over previous behavior), and morose demeanor within one to two weeks after beginning treatment.

While it may be argued that these symptoms may be indicative of depression, the more common depressive symptoms such as loss of appetite, sleep disturbances, constipation, etc., are conspicuously absent. In an unpublished study in 1971 (1), the symptom of depression, along with symptoms of hyperactivity, distractibility, and short attention span, is shown to be almost totally in remission with the administration of imipramine. Logically, it would follow that a remission of depressive symptomatology should occur since imipramine has been generally accepted as an effective antidepressant.

It is surmised that the sensitivity that appears in these children may reflect an actual guilt over previous behavior for which the child had been criticized, scolded, or even punished. Under the calming effect of medication, children in these cases may start reflecting over previous behavior and be rather guilt-ridden as a result of their introspection. While such children are obviously not responsible for their pretreatment behavior, it is very difficult to communicate this message to them without extended child therapy sessions, especially in the case of grade-school children. An easier solution has been the reduction in the dosage of medication or, in rare instances, discontinuation of the medication.

We suggest that clinicians and researchers explore this side effect further and investigate the possible biopsychosocial ramifications of this sensitivity reaction.

REFERENCE

1. Jorgensen SE: Utilization of an antidepressant psychoactive drug in the treatment of grade-school children handicapped by the hyperkinetic syndrome. DeKalb, Ill, Northern Illinois University Education Department, 1971 (unpublished paper)

W. S. RYBACK, M.D.
PHILIP A. JORGENSEN, A.C.S.W.
SHIRLEY E. JORGENSEN, M.S. ED.
Dixon, Ill.

Side Effects of Methylphenidate

SIR: In connection with a study on some hitherto undescribed side effects of methylphenidate hydrochloride (Ritalin), I was contacted by a salesman representing one of the major drug companies. He alerted me to the article "Effects of Imipramine and Dextroamphetamine on Behavior of Neuropsychiatrically Impaired Children" by Drs. Winsberg, Bialer, Kupietz, and Tobias (May 1972 issue). Since this is an area of interest to me, I took some care in reading this article.

The article is a prospective study in a conventional format with a sophisticated statistical analysis, but I believe there are a few errors in experimental design and interpretation of data that render this study of questionable value for its intended purpose.

First of all, the sample is inappropriate. It is a heterogeneous mixture of children with hyperactivity, minimal brain dysfunction, childhood schizophrenia, and "diagnosis uncertain" (authors' labels). Secondly, there is general improvement of most subjects as judged by Dr. Conners' Behavior Rating Scale (BRS) (1), but there is no improvement on a large battery of neuropsychological tests. This raises the question of the validity of one of these methods of measurement. Furthermore, the authors reach the conclusion that imipramine and dextramphetamine, used together, comprise a good therapeutic regimen. However, even if one believes in the validity of the BRS, the data presented in this paper do not support this conclusion. Finally, unless one is willing to change diagnostic labels to the different factors of the BRS, one cannot draw practical conclusions from this study.

Perhaps the most interesting aspect of this paper is its brief description of a child who hallucinated and experienced tactile delusions while on pharmacological doses of dextroamphetamine. Hallucinosis has been described previously after the use of stimulants in hyperactive children (2, 3). I am currently studying a group of children who have experienced tactile or somatic delusions following "normal" doses of methylphenidate hydrochloride. These phenomena may represent side effects, toxicity, or the unmasking capability of these drugs. In any case, there apparently exists a population of children bearing the symptom of hyperactivity who will react in this manner to stimulant therapy.

I believe that the paper of Dr. Winsberg and associates is one example of the kind of pharmacological empiricism that is characteristic of studies on children who manifest hyperactivity among other symptoms. It reveals the difficulties inherent in evaluating the statistical differences after drug administration when drugs are given to an undefined, highly variable population.

REFERENCES

1. Conners CK: A teacher rating scale for use in drug studies with children. Am J Psychiat 126:884–888, 1969
2. Ney PG: Psychosis in a child, associated with amphetamine administration. Can Med Assoc J 97:1026–1029, 1967
3. Lucas AR, Weiss M: Methylphenidate hallucinosis. JAMA 213:1079–1081, 1971

J. ROBERT ULLRICH
Orange, Calif.

Dr. Winsberg Replies

SIR: In response to Mr. Ullrich's letter, I would like to offer the following reply, organized around two principal areas: my belief that Mr. Ullrich has misinterpreted our data and a potentially substantive issue in his critique.

Mr. Ullrich suggests that we concluded that "imipramine and dextroamphetamine, *used together* [emphasis added], comprise a good therapeutic regimen" and that, further, "the data presented ... do not support this conclusion." Mr. Ullrich is wrong in the case of the first point and correct in the second. When we wrote of imipramine and dextroamphetamine as a "highly effective pair" of drugs we were referring to their effectiveness individually, not as concurrent treatment. Nowhere did we suggest, let alone "conclude," that the drugs be used cotemporaneously. If, on the other hand, Mr. Ullrich is referring to our suggestion that dextroamphetamine and imipramine be alternated to handle the problem of tolerance and that we have found this procedure effective, I would hope he appreciates that tolerance or rotational schedules were not the focus of this particular study. If he means something else, he will have to specify the problem more precisely.

In regard to the negative neuropsychological test data and BRS results, I believe Mr. Ullrich is suggesting that the BRS data might have occurred by chance or that either one of the two types of measures (behavioral and neuropsychological) may be invalid. This point might be of concern if one assumes that the two measures tapped the same behavioral dimension; however, the question of the validity of either the BRS or of the neuropsychological test data is independent of the negative findings on the latter tests. The problem of validity must be investigated by replication and cross validation of the data obtained. Such a study with the pharmacokinetics of imipramine is being initiated; among other things it will seek to replicate the previously obtained behavioral improvement. Problems attending the validity of findings constitute the bread and butter of all scientific research; however, they are not related to the issue Mr. Ullrich raises.

On the other hand, the issue he raised in regard to subject heterogeneity is of major practical and theoretical relevance. However, on the basis of his various objections, I do not feel he has the issue firmly in hand. He states that our sample was "inappropriate," that the population was "skewed toward the organic," and suggests—or perhaps misinterprets—that our itemization of the clinical diagnosis represents "labels" that the "authors" presumably applied. He further suggests that the data are uninterpretable unless "diagnostic labels" are rendered on the basis of the various factors on the BRS. I believe Mr. Ullrich confuses clinical description based on phenomenological criteria with that of etiological diagnosis.

In brief, I consider our subjects not to be "skewed" toward the organic but to *be* organic. In fact, I would not suggest drug therapy for behavior disorders unless I considered the patient to suffer from organic disease; I might otherwise be accused of treating the "non-ill." The evidence for organic brain pathology that we mobilized in our paper was addressed specifically to that diagnostic issue. The descriptive "labels" that our subjects received from other clinicians prior to the study were unacceptable as indices of organic pathology.

Space does not allow for a total elaboration of these issues and I can only refer Mr. Ullrich to some of the pertinent literature pertaining to diagnosis, e.g., Pollack (1, 2) and Knobloch and Pasamanick (3). These authors as well as many others have proposed that should evidence for organicity be present to account for psychopathology, it must be rendered as the primary diagnosis. Additionally, the *DSM-II* (4) is quite specific (the *ICD-8* [5] even more so) in regard to this problem. Our patients were then diagnosed as having chronic organic brain disease followed by a description of the behavioral pathology, e.g., hy-

peractivity, aggression, degree of mental defect, etc. From the above perspective our subjects were quite homogeneous and not at all undefined. Depending on what Mr. Ullrich means, they may or may not have been variable.

I hope I have addressed myself to the issues that Mr. Ullrich raises. If he has further questions or clarifications of his points that would require further comment, I would be glad to hear from him.

REFERENCES

1. Pollack M: Mental subnormality and "childhood schizophrenia," in Psychopathology of Mental Development. Edited by Zubin J, Jervis G. New York, Grune & Stratton, 1967, pp 460–472
2. Pollack M: Suspected early minimal brain damage and severe psychopathology in adolescence. Adolescence 14:361–384, 1969
3. Knobloch H, Pasamanick B: Prediction from the assessment of neuromotor and intellectual status in infancy, in Psychopathology of Mental Development. Edited by Zubin J, Jervis G. New York, Grune & Stratton, 1967, pp 387–400
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, second ed. Washington, DC, APA, 1968
5. World Health Association: International Classification of Diseases, 8th revision. Geneva, WHO, 1968

BERTRAND G. WINSBERG, M.D.
Brooklyn, N.Y.

BOOK REVIEWS

Television and Growing Up: The Impact of Televised Violence. *Report to the Surgeon General, U.S. Public Health Service. Washington, D.C., U.S. Government Printing Office, 1972, 169 pp., $2.25 (paper).*

This slim paperback summarizes the agonies, ambivalences, and scientific conclusions of the Surgeon General's Advisory Committee on Television and Social Behavior. The presentation is painfully fair, balanced, and cautious. The committee states that:

> The accumulated evidence does not warrant the conclusion that televised violence has a uniformly adverse effect, nor the conclusion that it has an adverse effect on the majority of children. . . . [*But*] violence depicted on television can immediately or shortly thereafter induce mimicking or copying by children. . . . Under certain circumstances televised violence can instigate an increase in aggressive acts.

Those children most likely to behave aggressively after viewing televised violence are those who are aggressive to begin with, who enjoy viewing violence, and who belong to an aggressive subgroup. And television is pervasive: "The average home set is on more than six hours a day." An average of eight violent episodes occur every hour.

The evidence for these conclusions, drawn from 60 papers commissioned by the Surgeon General's committee and available in five volumes of research reports, is described in sufficient detail to illustrate research methodology and the relative power of specific statistical results. Controlled laboratory experiments were employed with younger children to test the hypothesis that televised violence precipitates aggressive behavior (à la Bandura). In the adolescent sample, surveys of self-reports are analyzed to correlate viewing preferences, attitudes, and aggressive tendencies. One provocative longitudinal study is explained in depth. Lefkowitz and associates (1961–1971) compared 211 boys' preference for violent television programs in the third grade with peer-rated aggression among the same boys ten years later, in the 13th grade, and found a significant correlation of .31. However, this apparently powerful result depends "almost entirely on a small number of boys at the extreme high end of the preference scale who scored extremely high on the peer rated measure of aggression." The committee suggests that these individuals should be studied further.

The analysis of individual cases was not part of the research strategy, and from a psychiatric point of view this is a significant omission. For example, it would be pertinent for the clinician to have a richer understanding of emotionally disturbed, aggressive children, the impact of television in individual cases, and therapeutic approaches that might include strategies for altering television viewing behavior. Psychotherapists are concerned about the impact of television content on the hyperkinetic child, the retarded child, and the psychotic child. But, in all fairness, this report was prepared for a broad readership (Senator Pastore, the U.S. Congress, and the American public). Justifiably, nomothetic methods of sociology and psychology are emphasized.

Ample space is devoted to an explanation of the nature of research-by-commission: It is an intriguing blend of politics and science applied to questions of profound public concern in a brief period of time with a modest budget and an expectation of unequivocal, unanimous results. So of course it is no surprise that the Surgeon General has determined that some televised violence will adversely affect some children under certain conditions.

In sum, this is a document of some historic importance with some interesting scientific findings that should please some readers some of the time. And it is cheap.

FRANK M. OCHBERG, M.D.
San Francisco, Calif.

Modern Clinical Psychiatry, *8th ed., by Lawrence C. Kolb, M.D. Philadelphia, W.B. Saunders Co., 1973, 668 pp., $13.*

This eighth edition of the well-known work *Modern Clinical Psychiatry*, made famous by Noyes and Kolb, appears here for the first time without the name of Dr. Noyes emblazoned on the cover. His contributions to the text ended with his long illness. He died in 1963, but Dr. Kolb graciously notes that Dr. Noyes's influence clearly continues throughout the volume, and he points out some of the superb contributions that he made. Those who remember Dr. Noyes as an excellent clinician and teacher will have no difficulty recognizing some of the case reports or his writings on psychopathology.

Every chapter in the book has been rewritten, and up-to-date material has been added. The specialty has moved so fast in the past decade that this was necessary. In addition to being rewritten, chapters are reordered, and all is done in conformity with the most recent *International Classification of Diseases* (1).

There is not too much to say about this excellent textbook that has not already been said about one of its previous seven editions, except for the new additions made necessary by psychiatric, medical, and surgical advances. There is the same thoroughness and solidity to the chapters that one has come to expect. The neophyte who would start at the first chapter and go through to the last would get a liberal education. The experienced teacher and clinician will get a refurbishing. Some of the chapters will bear rereading at regular intervals.

The new material includes a medley of things. General systems theory is discussed in chapter 2, titled "Development of Dynamic Psychiatry." Attention is also given to such pressing contemporary subjects as poverty and racism. Community psychiatrists can testify as to the ravages of both. Hemodialysis, open heart surgery, and organ transplants come in for special attention. The chapter on drug dependence is well done; and chapter 28, "Behavior Disorders of Childhood and Adolescence," describes problems generally met with and treated during infancy, childhood, and adolescence. The last-mentioned life period bids fair to becoming a specialty in itself due to the

present-day conditions and culture. Chapter 29, titled "Special Symptoms," considers such conditions encountered in the treatment of children as speech and learning disorders, sleep disorders, and tics. Chapters 31 through 33 provide a broad spectrum of treatment modalities. The last chapter deals with psychiatry and the law.

The book is a vade mecum not only for the students and residents who are faced with examinations, but also for the seasoned practitioner and, in fact, for any physician motivated by the present pressures, external and internal, to continuing education.

REFERENCE

1. World Health Organization: International Classification of Diseases, 8th revision. Geneva, WHO, 1968

F.J.B.

Psychotherapy: Experience, Behavior, Mentation, Communication, Culture, Sexuality, and Clinical Practice, *by Donald J. Holmes, M.D. Boston, Little, Brown and Co., 1972, 1042 pp., $15.*

The title of this often pretentious book is misleading. Although the word "psychotherapy" appears as early as page 170, the subject as it is generally understood must wait until page 963 before it comes up for discussion. The lengthy lucubrations between include surveys of philosophy, religion, biology, anthropology, animal behavior, neurophysiology, developmental and cognitive psychology, history, and human sexuality (with coital positions illustrated).

In the introduction the author warns of the formidable accomplishment he essays, "to consider in careful detail the variety of inner and outer forces that contribute the most to making a person think, feel, and behave as he does" (p. xi). At the same time, he suggests that a leavening humor will keep the enormity of humanity within manageable perspective:

> The slow growth of religious thought and experience is also carefully and lovingly examined, especially as it affects the lives of persons now living and of those yet to be born. With this clinically relevant review of man in his milieu is a careful appraisal of human moral behavior, of the growing psychiatric ethic, of what is better and worse in human choosing behavior (p. xi).

Although the next thousand pages do, in fact, contain flashes of wit, clever turns of phrase, and amusing commentaries on many of man's (and traditional psychiatry's) most cherished notions, the overall effect is more irritating than stimulating, ponderous and tedious rather than lucid and incisive. In a discussion of experience as a determinant of present behavior, the author takes pointed exception to "Kubie's stab at the problem." He concludes the section with a sentence that dogged me as I plodded diligently on: "The less we know about something, the longer it takes to say" (p. 79).

It may well be that I am missing the forest for the trees, and I am not unmindful of what the author has to say about such errors in the fields of theology and philosophy: "Scholars bury themselves in details, then spend their leisure trying to demolish the good works of anyone foolhardy enough to attempt to find a point and a purpose in the history of man. . . . Blunders in minuscule details of scholarship counted for everything, while coherence and significance have counted for nothing" (p. 395).

The first two chapters of the book discuss man's place in evolution and in the animal taxonomy, with the author's thoughts about how genetic engineering might affect man in his crawl through history:

> Whatever other nice embellishments we may wish to add to any conception of ourselves, it is likely that our mutual ends are not well served by pretending we are something a great deal more than mere "bods"—protoplasmic, anthropoidal bodies—infectable, bruisable, killable, hateable, and lovable. It is also a stunning experience to realize that the choice of the ultimate disposition of our own species is our own to make (p. 38).

Because the volume ranges far and wide through so many fields of knowledge, the ordinary reader will probably feel it advantageous to consult the references listed for each chapter. If so, he will note an inconsistency of approach in both the footnotes and the references. In one chapter, for example, a book is cited and with it the specific page from which the statement was taken. A few paragraphs later, three references are given about the development of verbal skills in deaf children. These three articles are from different years of *The Year Book of Neurology, Psychiatry, and Neurosurgery*, with no indication of who the original authors were. Many of the footnotes contain objections by the author's expert consultants to statements in the body of the text, but the author makes no attempt to counter these objections. It is thus difficult to comprehend the purpose of such footnotes in the first place.

The sections on mental development and the mechanisms of defense are well done. The author's view of sexuality as elective varieties of behavior is a refreshing departure from the anachronistic attitude that sexual variants are, in the main, an expression of disease. Even in such generally commendable sections, however, the intrusion of stylistic peculiarities threatens to dim the luster of the message. In a paragraph discussing human sexuality and morality, for example, the following sentence appears: "In this part of the world especially, many subtle but powerful cultural trends suggest that these previously primary but ever less privy pleasure parts of the perineal pudenda are not the best—or even particularly pertinent—moral measure of a man, woman, or child" (p. 124).

Also interesting is the section on communications, which includes an essay on the development of languages and of printing, and the section on sexuality, which is essentially a summary of a course in sex education presented to medical students between 1966 and 1970. The photographs are technically of superior quality. What the author has finally to say about psychotherapy is enlightening, and the clinical illustrations are well chosen. That the relative brevity of the psychotherapy section is disappointing is an indication of its cogency and readability.

ROBERT J. CAMPBELL, M.D.
New York, N.Y.

The Crisis Team: A Handbook for the Mental Health Professional, *by Julian Lieb, M.B., Ian I. Lipsitch, M.D., and Andrew Edmund Slaby, M.D. New York, Harper & Row, 1973, 177 pp., $6.95 (paper).*

Good clinicians have practiced crisis intervention with their psychiatric patients for a long time. Short-term goal-directed therapy, attention to familial and environmental influences, and judicious use of medication have all been in the armamentarium

of the broadly trained and pragmatic general psychiatrist. Nevertheless, the formal application of crisis intervention within the context of a general hospital, private psychiatric hospital, and community mental health center is relatively new and may well be changing the face of modern psychiatric hospital treatment. Many hospitals, such as Veterans Administration hospitals, that in the past were considered medium-term and long-term care facilities have found that crisis intervention techniques can dramatically reduce the average length of stay. Certainly, psychiatric units in general hospitals should be organized around the concept of crisis intervention, if for no other reason than to reduce the cost of psychiatric care.

For those who want to move in the direction of more formal utilization of crisis intervention techniques, *The Crisis Team*, originating from work at the Connecticut Mental Health Center, is an excellent how-to-do-it book. It is well written, concise, and practical. Although it seems to be aimed more toward the nonpsychiatric members of the team, the psychiatrist who is not familiar with the setup and functioning of a crisis intervention unit can profit greatly from the book. The book will also be of value to all new staff members coming on to an inpatient psychiatric unit, even if the unit is not entirely geared to crisis intervention. Nurses, social workers, psychiatric aides, and technicians can all learn from this book.

Following a brief history of crisis intervention and a description of how it is distinguished from longer-term psychotherapeutic techniques, the authors discuss the makeup and function of the crisis intervention team. They describe the kinds of patients who are treated in a crisis intervention unit, the evaluation and treatment processes, and discharge planning. Appendixes contain psychosocial history forms, both computerized and noncomputerized. For those new to a psychiatric unit, the section titled Illustrative Examples of Crisis Intervention will be especially useful. This section illustrates the range of patient problems handled by such a unit. Patients with various problems are described, and examples of their treatment and disposition are given.

Those who want to learn about the theory of crisis intervention must look elsewhere. This book is more for those who have already decided that crisis intervention is the way to go and that the crisis intervention team is the vehicle to use. Much is made of the fact that mental health workers from the neighborhoods are a great help in delivering mental health services to patients from lower socioeconomic groups. This is true, but it is not mentioned that these patients also want to see the "doctor" or, as some studies have shown, that when given a choice, they will opt for the psychiatrist rather than the mental health worker.

Obviously there is much yet to learn about crisis intervention—how it should best be done and who can best do it—but it has changed and will continue to change the approach of psychiatric inpatient treatment.

ROBERT L. LEON, M.D.
San Antonio, Tex.

130 Jahre: Deutsche Geselschaft für Psychiatrie und Nervenheilkunde, *by Helmut E. Ehrhardt. Wiesbaden, Germany, Franz Steiner Verlag, 1972, 125 pp., DM 18 (paper).*

This a highly interesting chronicle covering the 130-year lifespan of the German Association for Psychiatry and Neurology. The author, for many years the association's secretary and recently its president, has chosen an original method of presentation that lets the facts speak for themselves. He achieves this by providing a comprehensive spectrum of documentation that includes the minutes and scientific programs of 100 meetings, protocols pertaining to organizational reforms, lists and portraits of the members who have served in high offices, and the full texts of programs sponsored to meet the evolving requirements of services for all facets of mental health and illness. Many of these data are published for the first time, giving illuminating insight into the trends and attitudes of German psychiatry.

The material is divided into that from periods before and after 1945, with the focus on the postwar era. The reader thus gains an understanding of the impact of political events on the organization's professional progress and setbacks. This brief but richly documented book provides a fascinating account of the emancipation of German psychiatry as an independent science and of the association's expanding role as a public-health-oriented professional power. The author succeeds in proving his premise that the history of a scientific organization serves as a mirror of the intrinsic problems of the science that have to be resolved before the science can assume its proper identity. The reader is left with the impression that German psychiatry has, through its official organization, bridged the gap between scientific isolation and national and international involvements on many levels of collaborative enterprises and aspirations.

FRITZ A. FREYHAN, M.D.
Washington, D.C.

Psychotomimetic Drugs, *edited by Daniel H. Efron, M.D., Ph.D. New York, Raven Press, 1970, 350 pp., $15.95.*

This book is the result of an NIMH-sponsored interdisciplinary meeting of scientists and clinicians in January 1969. The group of psychiatrists, pharmacologists, psychologists, biochemists, and neurophysiologists presented 17 papers. The broad range of material presented is illustrated by the titles of two of the papers: "Stereochemical and Membrane Studies with the Psychotomimetic Glycolate Esters" (by Abood) and "Children's Reactions to Psychotomimetic Drugs" (by Bender). The intensity of the two-day meeting is indicated by the 12-hour working sessions that took place each day. An enthusiastic give-and-take occurred; almost one-third of the book is devoted to the discussions that followed the papers. The workshop avoided the complicated social and legal issues as it directed its attention to the scientific aspects of psychotomimetic compounds.

In the opening paper Shulgin presents an interesting overview of the relationship between the psychotomimetic compound's chemical structure and its activity. He emphasizes the marked change in activity that often occurs with only a slight change in the compound's structure. Snyder and Richelson point out the difficulties involved in making in-vivo studies. They discuss tryptamine derivatives and phenylethylamines and give a particularly extensive analysis of the amphetamines and their derivatives. Abood, noting the improved methods for investigating the complex membrane system, gives a brief but highly informative presentation of the relationship between the stereochemical structure of a drug and its potency.

Sulser and Sanders-Bush offer a thorough comparison of the possible direct and/or indirect central action of the amphetamines and comment upon the difficulty of identifying the specific adrenergic receptor site involved. They also describe the effects of tricyclic antidepressants and chlorpromazine on the action of amphetamines.

Stein and Wise also review the evidence pertaining to possible amphetamine pathways. They found that amphetamine

does release norepinephrine from synapses of the medial forebrain bundle, and their evidence suggests that the norepinephrine so released acts as a depressant of the activity of behaviorally suppressive cell groups of the forebrain. Additional experiments led to their conclusion that the action of amphetamine depends upon the availability of norepinephrine in functional pools.

A paper by Aghajanian, Sheard, and Foote comparing the effects of LSD and mescaline on single units in the midbrain raphé is of particular interest because of their description of a specific set of brain neurones that are markedly sensitive to these two compounds. Their studies appear to be an important neurophysiological first step, since they found that the effects of mescaline on raphé units were similar, but not identical, to those of LSD.

In their well-documented paper, Winters and Wallach postulate that hallucinatory activity occurs as a result of a loss of reticular modulation of the sensory systems, thus producing an ongoing state of central nervous system excitability. In his excellent review and overview Lipton notes the tempting opportunities and many disappointments in the use of psychotomimetic drugs in the exploration of possible biochemical factors in schizophrenia. Comparing two of the newer psychotropic agents (2,5-dimethoxy-4-ethylamphetamine [DOET] and 2,5-dimethoxy-4-methylamphetamine [DOM]) with d-amphetamine, Snyder, Weingartner, and Faillace found that DOET produced mild subjective euphoria and enhanced self-awareness in the absence of hallucinogenic effects. These results prompted one of the conference participants to suggest exploring its potential as an antidepressant.

Dr. Lauretta Bender's paper was particularly interesting in its brief history of the use of amphetamines in the treatment of hyperkinetic children. Beginning in 1961, her group used LSD with autistic children. They found a significant improvement in both appearance and mood, but discontinued its use in 1965 due to the reports of chromosomal damage and the fact that the pharmaceutical company that had been producing it for research purposes ceased doing so.

Griffith, Cavanaugh, and Oates intensively studied four adult male volunteers who were given large doses of d-amphetamine for a period of one to five days. All four subjects developed a paranoid psychotic state with no evidence of disorientation or alteration of consciousness. Caldwell, Myers, and Domino measured the effect of marijuana "highs" on various sensory thresholds and found a significant difference between the controls, who smoked alfalfa cigarettes, and the marijuana group on only one test (auditory amplitude).

The workshop papers (including those not mentioned here) and discussions were absolutely packed with information, often of a highly technical nature. Although this book clearly has much more for the researcher than for the clinician, the "mind-expanding" workshop succeeds in its purpose of disseminating information and communicating across disciplines.

CHARLES W. BOREN, M.D.
Hartford, Conn.

This Month's Reviewers

FRANK M. OCHBERG, M.D., is Associate Regional Health Director for Mental Health, Department of Health, Education, and Welfare, Region IX, San Francisco, Calif.

ROBERT J. CAMPBELL, M.D., is Associate Director, Department of Psychiatry, St. Vincent's Hospital and Medical Center of New York, N.Y.

ROBERT L. LEON, M.D., is Professor and Chairman, Department of Psychiatry, University of Texas Medical School, San Antonio, Tex.

FRITZ A. FREYHAN, M.D., is in private practice in Washington, D.C.

CHARLES W. BOREN, M.D., is Chief of Section, Institute of Living, Hartford, Conn.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

C.G. Jung: Letters, vol. 1: 1906–1950, *edited by Gerhard Adler with Aniela Jaffé. Princeton, N.J., Princeton University Press, 1973, 576 pp., $17.50.*

Drugs: An Annotated Bibliography and Guide to the Literature, *by Alfred M. Ajami, Jr. Boston, G.K. Hall & Co., 1973, 205 pp., $15.*

Annie Reich: Psychoanalytic Contributions. *New York, International Universities Press, 1973, 368 pp., $13.50.*

The Child in His Family, vol. 2: The Impact of Disease and Death, *edited by E. James Anthony, M.D., and Cyrille Koupernik, M.D. New York, John Wiley & Sons, 1973, 506 pp., $15.95.*

Aggression: A Social Learning Analysis, *by Albert Bandura, Ph.D. Englewood Cliffs, N.J., Prentice-Hall, 1973, 366 pp., $8.95.*

Brain's Clinical Neurology, *4th ed., revised by Roger Bannister, D.M. New York, Oxford University Press, 1973, 426 pp., $11.50 (paper).*

Advances in Neurology, vol. 1: Huntington's Chorea, 1872–1972, *edited by André Barbeau, M.D., Thomas N. Chase, M.D., and George W. Paulson, M.D. New York, Raven Press, 1973, 801 pp., $48.*

Sexual Freedom and the Constitution, *by Walter Barnett, LL.M. Albuquerque, University of New Mexico Press, 1973, 324 pp., $10.*

Sisyphus *or* The Limits of Education, *by Siegfried Bernfeld, translated by Frederic Lilge. Berkeley, University of California Press, 1973, 120 pp., $6.75.*

Talking with Patients, *2nd ed., by Brian Bird, M.D. Philadelphia, J.B. Lippincott Co., 1973, 354 pp., $10.*

Cry Anger: A Cure for Depression, *by Jack Birnbaum, M.D. Don Mills, Ontario, Canada, General Publishing Co., 1973, 190*

pp., $7.95.

Our Bodies, Ourselves: A Book By and For Women, *by the Boston Women's Health Book Collective. New York, Simon and Schuster, 1973, 276 pp., $2.95 (paper).*

Aging & Mental Health: Positive Psychosocial Approaches, *by Robert N. Butler, M.D., and Myrna I. Lewis. St. Louis, C.V. Mosby Co., 1973, 289 pp., $5.95 (paper).*

Children and Dying: An Exploration and a Selective Bibliography, *by Sarah Sheets Cook, R.N. New York, Health Sciences Publishing Corp., 1973, 37 pp., $1.95 (paper).*

Group Training for Individual and Organizational Development, *edited by Cary L. Cooper. New York, S. Karger, 1972, 166 pp., $18.60.*

The Victim Is Always the Same, *by I.S. Cooper, M.D. New York, Harper & Row, 1973, 160 pp., $6.95.*

Confrontations with Myself: An Epilogue, *by Helene Deutsch, M.D. New York, W.W. Norton & Co., 1973, 217 pp., $6.95.*

Alcohol: Our Biggest Drug Problem, *by Joel Fort, M.D. New York, McGraw-Hill Book Co., 1973, 171 pp., $6.95.*

Family Roots of School Learning and Behavior Disorders, *edited by Robert Friedman, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 338 pp., $14.75.*

The Psychiatric Outpatient: Clinical and Organizational Aspects, *by Lynn Gillis, M.D., D.P.M., and Stella Egert. London, Faber and Faber, 1973, 127 pp., £2.40.*

Population and The Population Explosion: A Bibliography for 1970, *by Stephen H. Goode. Troy, N.Y., Whitston Publishing Co., 1973, 345 pp., $17.*

Decision Therapy, *by Dr. Harold Greenwald. New York, Peter H. Wyden, 1973, 308 pp., $6.95.*

When Mother Is a Prefix: New Directions in Youth Correction, *by Nelson Henry. New York, Behavioral Publications, 1972, 129 pp., $7.95.*

Loving Free, *by Jackie and Jeff Herrigan. New York, Grosset & Dunlap, 1973, 312 pp., $7.95.*

Psychoses Collectives et Suicides Collectifs, *by Georges Heuyer. Vendôme, France, Presses Universitaires de France, 1973, 125 pp., no price listed (paper).*

The Awakening Nightmare: A Breakthrough in Treating the Mentally Ill, *by Albert M. Honig. New York, Dell Publishing Co., 1973, 299 pp., $2.65 (paper).*

Early Human Development, *edited by S.J. Hutt and Corinne Hutt. New York, Oxford University Press, 1973, 360 pp., $9.50 (paper).*

Law, Psychiatry and the Mentally Disordered Offender, vols. 1 and 2, *edited by Lynn M. Irvine, Jr., and Terry B. Brelje, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 143 pp.; 126 pp., $9.75 each.*

Pediatric Neurology Handbook, *by J.T. Jabbour, M.D., Danilo A. Duenas, M.D., Richard C. Gilmartin, Jr., M.D., and Marvin I. Gottlieb, Ph.D., M.D. Flushing, N.Y., Medical Examination Publishing Co., 1973, 466 pp., $10 (paper).*

Visceral Learning: Toward a Science of Self-Control, *by Gerald Jonas. New York, Viking Press, 1973, 148 pp., $6.95.*

The Terminal Patient: Oral Care, *edited by Austin H. Kutscher, Bernard Schoenberg, and Arthur C. Carr. New York, Columbia University Press (distributor), 1973, 257 pp., $12.50.*

Wisconsin Death Trip, *by Michael Lesy. New York, Pantheon Books, Random House, 1973, unnumbered pages, $5.95 (paper).*

Home from the War; Vietnam Veterans: Neither Victims nor Executioners, *by Robert Jay Lifton. New York, Simon and Schuster, 1973, 461 pp., $8.95.*

Effective Approaches to Patients' Behavior, *by Gladys B. Lipkin, R.N., M.S., and Roberta G. Cohen, R.N., M.S. New York, Springer Publishing Co., 1973, 198 pp., $4.75 (paper).*

Sexual Disorders and Allied Conditions: The Psychopathology of Scatism, *by S.M.A. Malik. Surrey, England, Roseneath Scientific Publications, 1973, 202 pp., £4.80.*

Love and Will, *by Rollo May. New York, Dell Publishing Co., 1973, 343 pp., $2.95 (paper).*

Biological Psychiatry, *edited by Joseph Mendels, M.B., Ch.B., M.D. New York, John Wiley & Sons, 1973, 487 pp., $24.95.*

My Own Woman: The Diary of an Analysis, *by Suzanne Mitchell. New York, Horizon Press, 1973, 269 pp., $7.95.*

Groups: Theory and Experience, *by Rodney W. Napier and Matti K. Gershenfeld. Boston, Houghton Mifflin Co., 1973, 305 pp., $9.50.*

Bibliography on Drug Abuse: Prevention, Treatment, Research, *by the National Institute for Drug Programs, Center for Human Services. Washington, D.C., Human Service Press, 1973, 209 pp., $7.95 (paper).*

Gender Differences: Their Ontogeny and Significance, *edited by Christopher Ounsted and David C. Taylor. Baltimore, Williams & Wilkins Co., 1973, 262 pp., $17.*

Cannabis and Its Derivatives: Pharmacology and Experimental Psychology, *edited by W.D.M. Paton and June Crown. New York, Oxford University Press, 1973, 196 pp., $16.*

Psychosocial Aspects of Cystic Fibrosis, *edited by Paul R. Patterson, Carolyn R. Denning, and Austin H. Kutscher. New York, Columbia University Press (distributor), 1973, 215 pp., $12.50.*

Letters to Simon: On the Conduct of Psychotherapy, *by I.H. Paul. New York, International Universities Press, 1973, 341 pp., $12.50.*

Behavior Modification in Residential Treatment for Children: Model of a Program, *by Frank J. Pizzat, Ph.D. New York, Behavioral Publications, 1973, 96 pp., $7.95.*

Screening and Assessment of Young Children at Developmental Risk, *by the President's Committee on Mental Retardation. Washington, D.C., U.S. Government Printing Office, 1973, 188 pp., $2.35 (paper).*

Background Papers of the Boston Conference: Screening and Assessment of Young Children at Developmental Risk, *by the President's Committee on Mental Retardation. Washington, D.C., U.S. Government Printing Office, 1973, 70 pp., 95¢ (paper).*

Soviet Psychology: Philosophical, Theoretical, and Experimental Issues, *by Levy Rahmani. New York, International Universities Press, 1973, 425 pp., $17.50.*

Conflict, Violence, and Morality in a Mexican Village, *by Lola Romanucci-Ross. Palo Alto, Calif., National Press Books, 1973, 202 pp., $2.95 (paper).*

Women and Sex, *by Leah Cahan Schaefer, Ed.D. New York, Pantheon Books, Random House, 1973, 269 pp., $8.95.*

How Behavior Means, *by Albert E. Scheflen. New York, Gordon and Breach, 1973, 167 pp., $9.95.*

Child and Adolescent Development: Laboratory-Field Relationships, *edited by Alvin M. Snadowsky, Ph.D. New York, Free Press, Macmillan Co., 1973, 302 pp., $4.95 (paper).*

The Law and Mental Disorder, *revised and edited by Barry B. Swadron, LL.B., LL.M., and Donald R. Sullivan, LL.B. Toronto, Canada, Canadian Mental Health Association, 1973, 186 pp., $6.50.*

An MMPI Source Book, *by Wendell M. Swenson, John S. Pearson, and David Osborne. Minneapolis, University of Minnesota Press, 1973, 150 pp., $9.50.*

The Age of Madness, *edited by Thomas S. Szasz, M.D. Garden City, N.Y., Anchor Press, Doubleday & Co., 1973, 362 pp., $2.95 (paper).*

Acupuncture Therapy: Current Chinese Practice, *by Leong T. Tan, M.D., Margaret Y.-C. Tan, M.S., and Ilza Veith, Ph.D. Philadelphia, Temple University Press, 1973, 159 pp., $15.*

Sexual and Marital Health: The Physician as a Consultant, *by Clark E. Vincent. New York, McGraw-Hill Book Co., 1973, 293 pp., $7.95.*

This Is Psychiatry, *2nd ed., by Felix von Mendelssohn, M.D. New York, Intercontinental Medical Book Corp., 1973, 245 pp., $8.75.*

The Solution of Social Problems: Five Perspectives, *edited by Martin S. Weinberg and Earl Rubington. New York, Oxford University Press, 1973, 310 pp., no price listed (paper).*

Psychoanalytic Sociology: An Essay on the Interpretation of Historical Data and the Phenomena of Collective Behavior, *by Fred Weinstein and Gerald M. Platt. Baltimore, Johns Hopkins University Press, 1973, 122 pp., $8.50.*

Problem Pregnancy and Abortion Counseling, *edited by Robert R. Wilson. Saluda, N.C., Family Life Publications, 1973, 120 pp., $3.45 (paper).*

OFFICIAL ACTIONS

Position Statement on Aging

This statement was approved by the Executive Committee of the American Psychiatric Association at its February 23, 1973, meeting, upon recommendation of the Council on Mental Health Services. It was prepared by the Task Force on Aging.[1] *The Executive Committee of the Assembly of District Branches endorsed the statement by mail vote in March 1973.*

THE AMERICAN PSYCHIATRIC ASSOCIATION is dedicated to the proposition that there must be comprehensive and effective delivery of mental health services for all citizens. Today there is urgent need for an improvement in the mental and physical health care of elderly citizens and a guarantee of a quality of life that they richly deserve. A comprehensive system of health care should be established that provides for: the proper evaluation of the individual's health needs; psychiatric, medical, social, and supportive measures not only to maintain health but to rehabilitate the sick and infirm; continuity and long-term care when and where necessary; and preventive health measures together with a continuing education program encouraging the preservation of health in all ages.

1. The health services provided by hospitals and agencies should be carefully correlated and integrated with those centers providing for the general well-being of the aged. Good home care and outreach community services are appropriate for some of the aged. These services cannot, however, supplant good public and private hospital facilities when the patient has a physical or mental illness that requires intensive or long-term care. In general hospitals the geriatric patients should have the same quality of inpatient and outpatient care as all other patients. Clinical and laboratory services in general hospitals greatly facilitate the evaluation of the elderly patient's problem and immeasurably aid in the decision concerning disposition.

Inpatient and outpatient facilities in state psychiatric hospitals should be upgraded and expanded to provide for those elderly patients whose mental and physical problems demand long-term care in a hospital. The use of proprietary nursing homes that do not afford adequate treatment as residences for those who have grown old in state hospitals should be discouraged.

Expanded social services should be available to provide the best possible care in a comprehensive health system that integrates state hospitals, general hospitals, community mental health centers, and the private physician.

2. Many aged who are not necessarily psychiatrically ill may have their needs for protective care best served in comfortable, friendly, homelike congregate living accommodations with adequate psychiatric supervision and a care-taking staff. This is true not only for many who personally desire this, but also for those whose families, because of psychological, socioeconomic, or hygienic reasons, cannot render the care that is necessary to the patient in today's complex social order.

3. A substantial increase in financial support for all medical and psychiatric services to the aged is immediately necessary. A national health system involving a public-private partnership in the delivery of these services, including quality controls to assure the best possible health benefits for all citizens, should be evolved. Funds should be made available from the federal, state, county, and city governments. Third-party payment and fees from patients that do not impose a financial burden could help financially undergird these services. Medicare benefits should be increased in the following manner: a) there should be elimination of all deductibles; b) psychiatric services, including outpatient care, should be paid for on the same basis as other medical services; c) the extended care facilities that are available to other types of patients should be available to psychiatric patients; d) there should be no exclusion of psychiatric patients from nursing home care when this is the most helpful resource for them; e) payment for necessary prostheses to improve the physical and mental status of the patient should be made.

Funds should be divided among services, research, and education. Monies should be distributed in a way that will not rob basic research in the field of gerontology nor trammel the investigation of new methods of delivery of health services to the aged.

4. The curricula of medical schools should definitely provide for the teaching of geriatric medicine—not only medical and surgical illnesses, but psychiatric illnesses as well. Not only should the education of specialists be encouraged, but the residency educational program in all services should emphasize the

[1] The task force included Drs. Alvin I. Goldfarb, Chairman, Jack Weinberg, Martin A. Berezin, Maurice E. Linden, Charles M. Gaitz, and Robert H. Dovenmuehle.

health problems of the aged. The subject should also be a part of the continuing education of psychiatrists. Teaching centering around the needs of the elderly should be included in the educational programs of nurses, psychologists, social workers, clergymen, health administrators, hospital aides, and all those whose efforts can make the lives of elderly people more rewarding and tranquil. When possible, the aged themselves should be encouraged to take part in these educational programs.

5. The American Psychiatric Association strongly urges the establishment of a Center on Aging in the National Institute of Mental Health. The Association pledges its active participation in the establishment of a National Institute on Aging and recommends that special emphasis be given in this institute to the study of biomedical problems. The American Psychiatric Association also urges the President to appoint an interdisciplinary commission on aging to study the problems of the aged and to recommend policies ensuring elderly citizens a quality of life in keeping with the dignity that is their right. The American Psychiatric Association would actively participate in the deliberations of such a body to help assure that proper emphasis is given to the mental health needs of our aged citizens.

Committee on Certification in Administrative Psychiatry

The following are those who successfully completed the committee's examination given in Honolulu, Hawaii, May 7, 1973.

Barton, William R., M.D., Rochester, N.Y.

Delaney, John R., St. Petersburg, Fla.

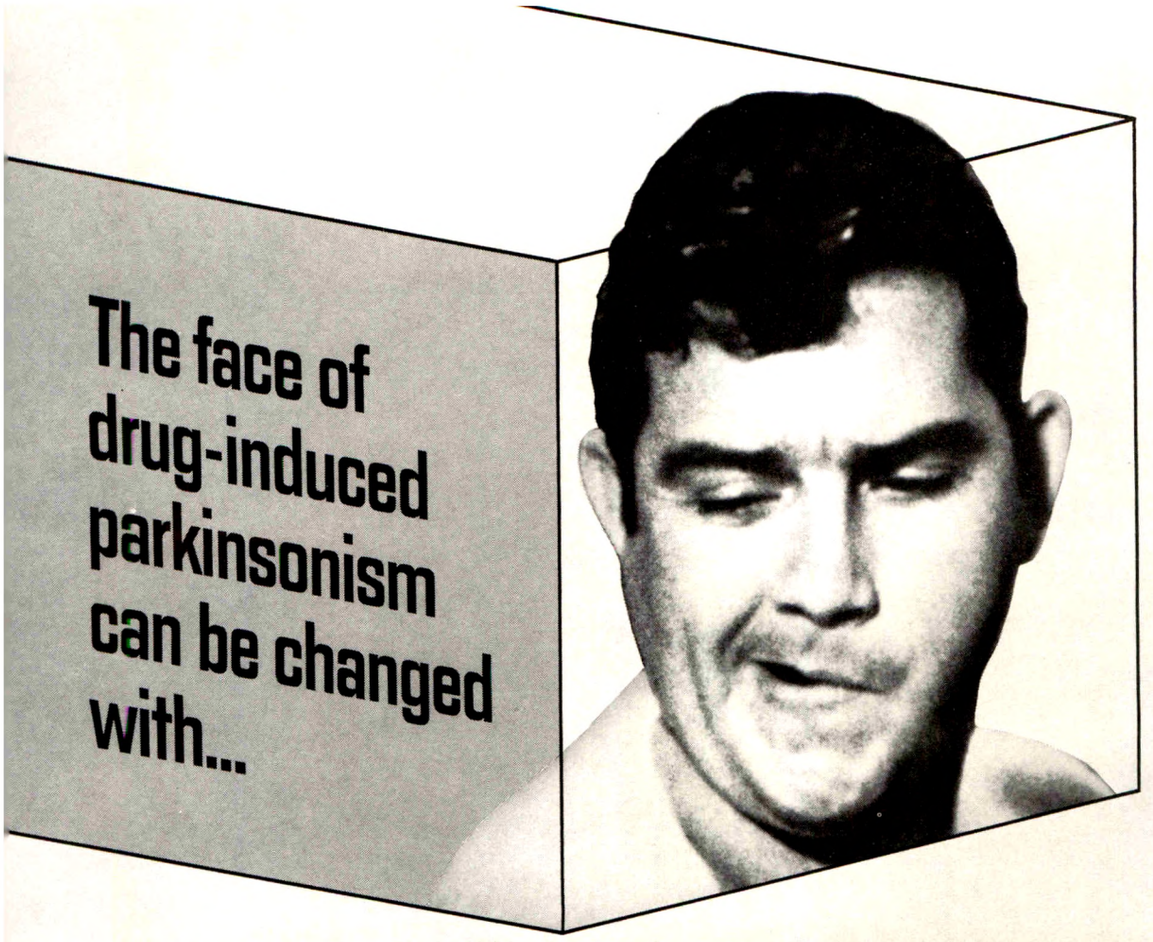
Kallen, Arnold M., M.D., Millburn, N.J.

Markiewicz, Wigdor, M.D., Cleveland, Ohio

Neal, M.W., M.D., Albuquerque, N. Mex.

Ristich, Miodrag, M.D., Staten Island, N.Y.

Sleszynski, Raymond A., M.D., St. Petersburg, Fla.



AKINETON®
(biperiden)

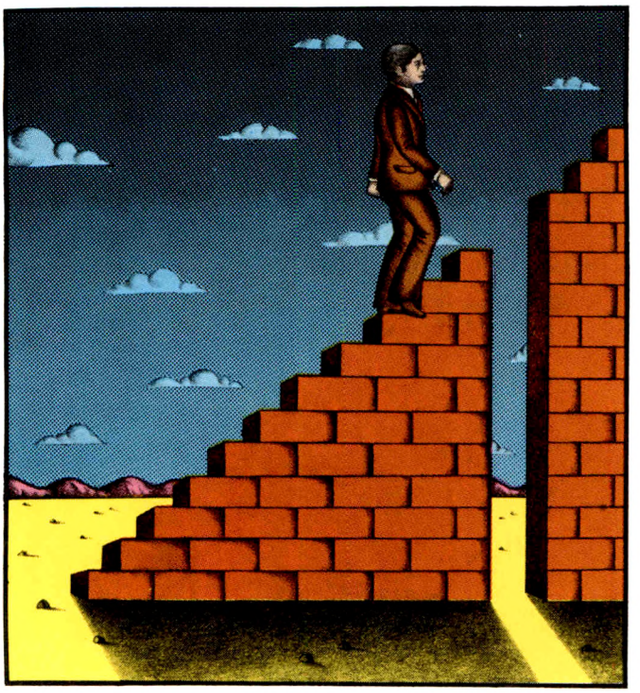
- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally: **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA

The psychoneurotic patient's prognosis may be good...

As a group, psychoneurotic patients tend to respond positively to psychotherapy. Follow-up studies indicate that up to two-thirds of treated patients may show significant and often sustained improvement.



In individual cases, the prognosis appears particularly favorable for the psychoneurotic who has had a good premorbid personality structure and a record of reasonably good interpersonal competence. As might be expected, patients judged to be "attractive" candidates for therapy often tend to derive greater benefits from therapeutic intervention than those considered "unattractive."

The global assessment of "attractiveness" is influenced by such factors as youthfulness, intelligence, ability to relate and good occupational history.

But excessive anxiety can block recovery...

Anxiety is the hallmark of psychoneurotic states. In excess it may not alter the patient's "prognostic rating," but it can slow therapeutic progress—sometimes to a marked extent. At the outset of therapy, for instance, severe or persistent anxiety can be particularly

obstructive, sometimes hampering for long periods the patient's ability to participate in a productive psychotherapeutic relationship. At later stages, intense anxiety may impair the patient's receptivity to further probing and block his attempts to retrieve and express pertinent material.

When the patient's disabling anxiety continues to impede therapeutic progress, management of his condition may often be significantly facilitated by adjunctive Librium (chlordiazepoxide HCl).

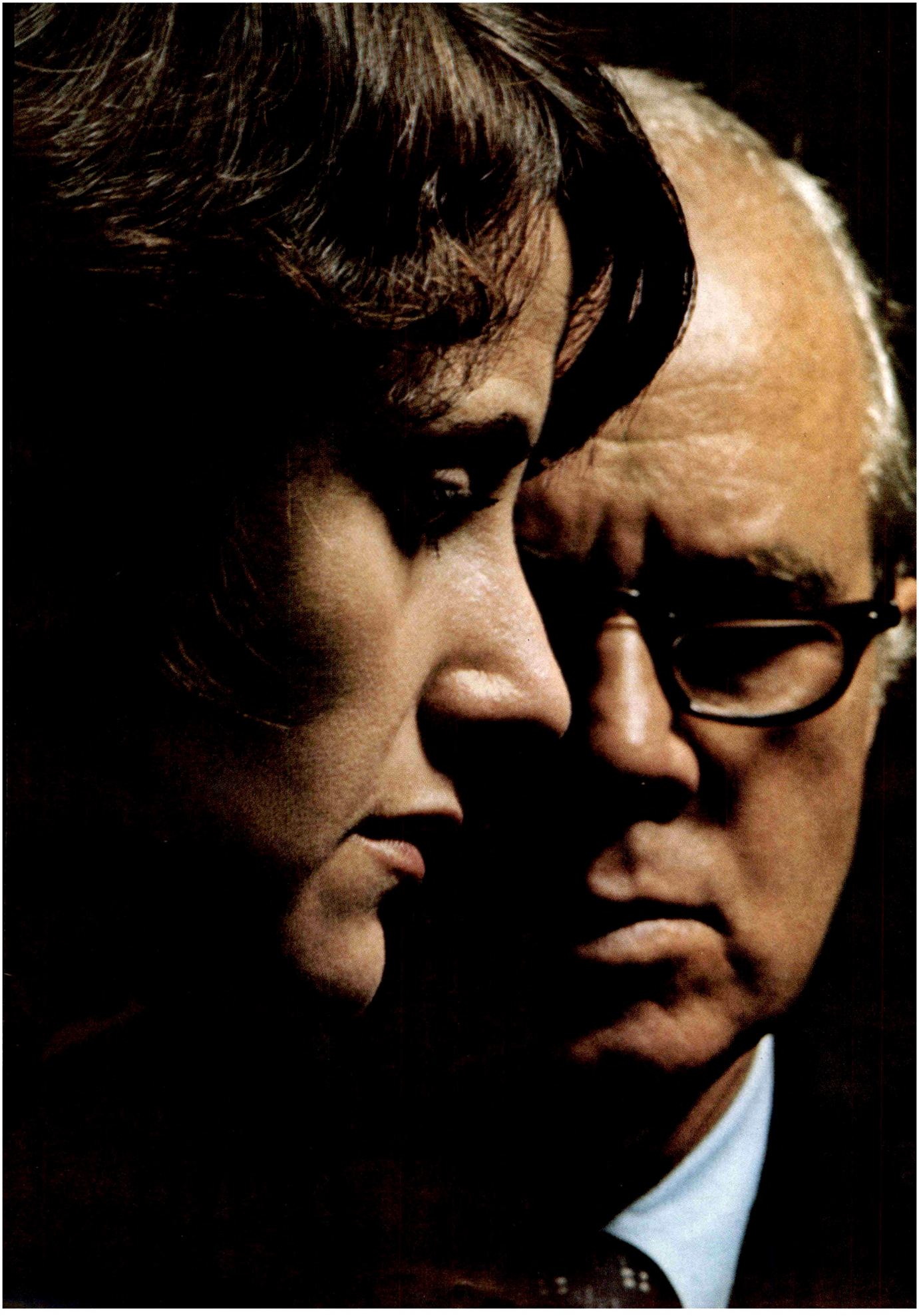
Librium generally relieves excessive anxiety without unduly impairing mental acuity or ability to perform. As with all CNS-acting drugs, however, patients should be cautioned against hazardous occupations requiring complete mental alertness. (See Warnings section in summary of prescribing information.) When the patient's anxiety has been reduced to appropriate levels, Librium should, of course, be discontinued.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

To relieve obstructive anxiety consider Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules
Up to 100 mg daily for severe anxiety

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



The TRIAVIL® Potential in the management of moderate to severe anxiety with depression

When time and talk are not enough...
The therapist is the primary catalyst for change in the psychotherapeutic relationship. However, when patients suffer from moderate to severe anxiety with depression, there are situations when TRIAVIL can often be a useful adjunct.

...TRIAVIL may help
There are three important benefits you may expect when TRIAVIL is part of the treatment program: (1) When symptoms of moderate to severe anxiety or agitation with depression are relieved, the patient may become more accessible and cooperative. (2) As somatic manifestations are controlled, attention may be focused on underlying causative factors. (3) Symptomatic relief may enable the patient to function more effectively in his daily life while your work with the patient progresses.

Since it is simpler to remember to take one tablet rather than several (particularly in multiple daily doses), your patients on TRIAVIL will be more likely to take proper doses of the medication. And, of course, economy is an added factor in therapy with TRIAVIL.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

MSD
MERCK SHARP & DOHME

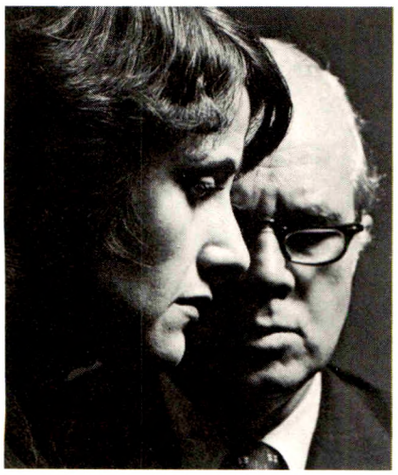
For a brief summary of prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression

TRIAVIL® (containing perphenazine and amitriptyline HCl)

an antidepressant tranquilizer

when patients exhibit moderate to marked anxiety
or agitation with symptoms of depression



TRIAVIL® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practice
when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.
A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.
If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.
Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.
Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential.
Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyper-reflexia, dystonia, akathisia, dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and EKG abnormalities (quinidine-like effect); reactivation of psychotic

processes; catatonic-like states; autonomic reactions, such as dryness of the mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitivity; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastic distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance — vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

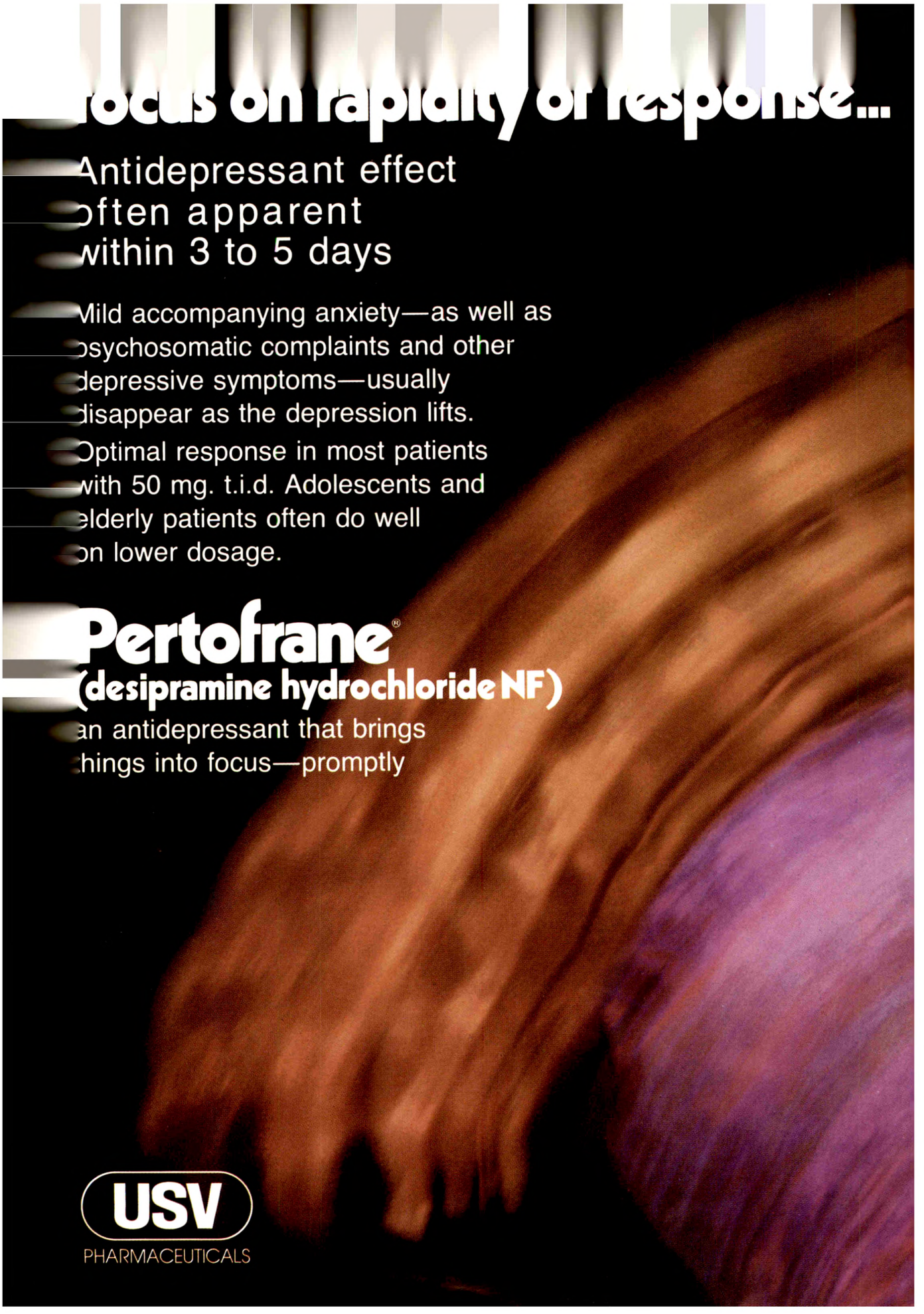
Anxiety Amelioration — in terms of motor, affective, autonomic and verbal phenomenon.

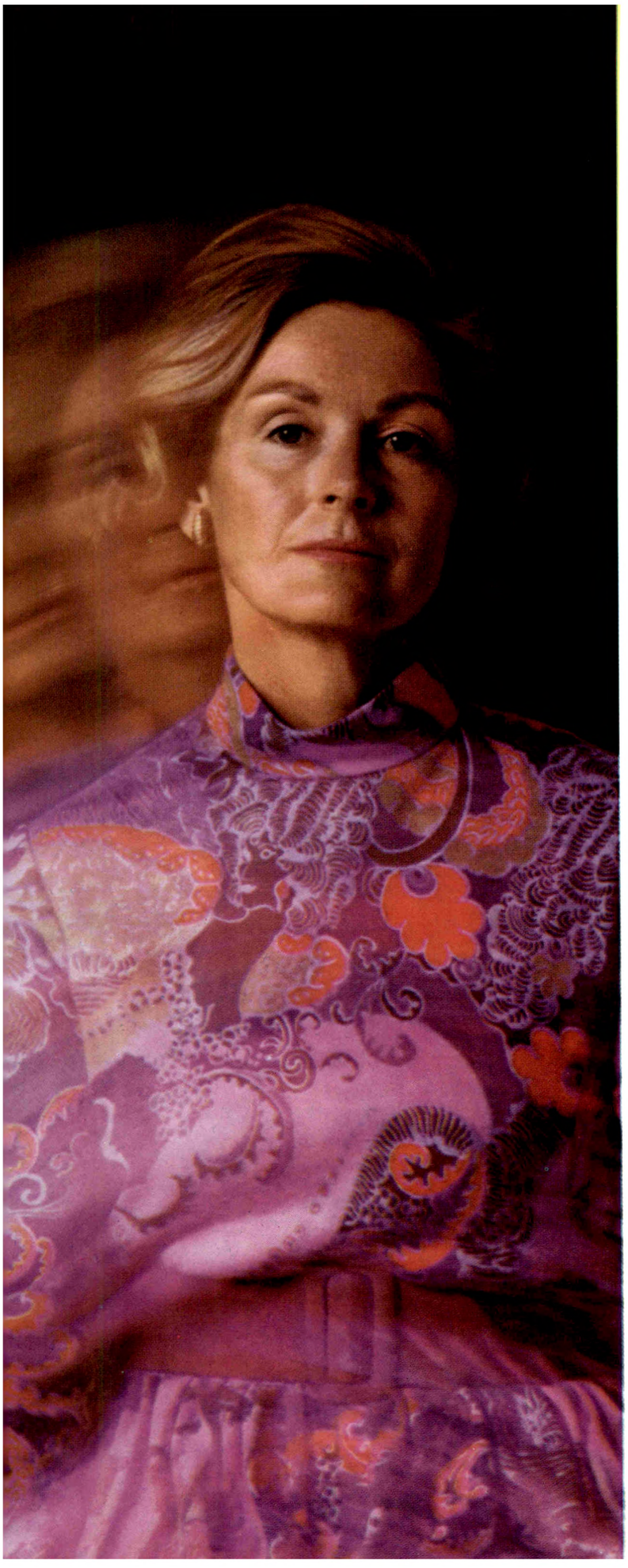
1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.

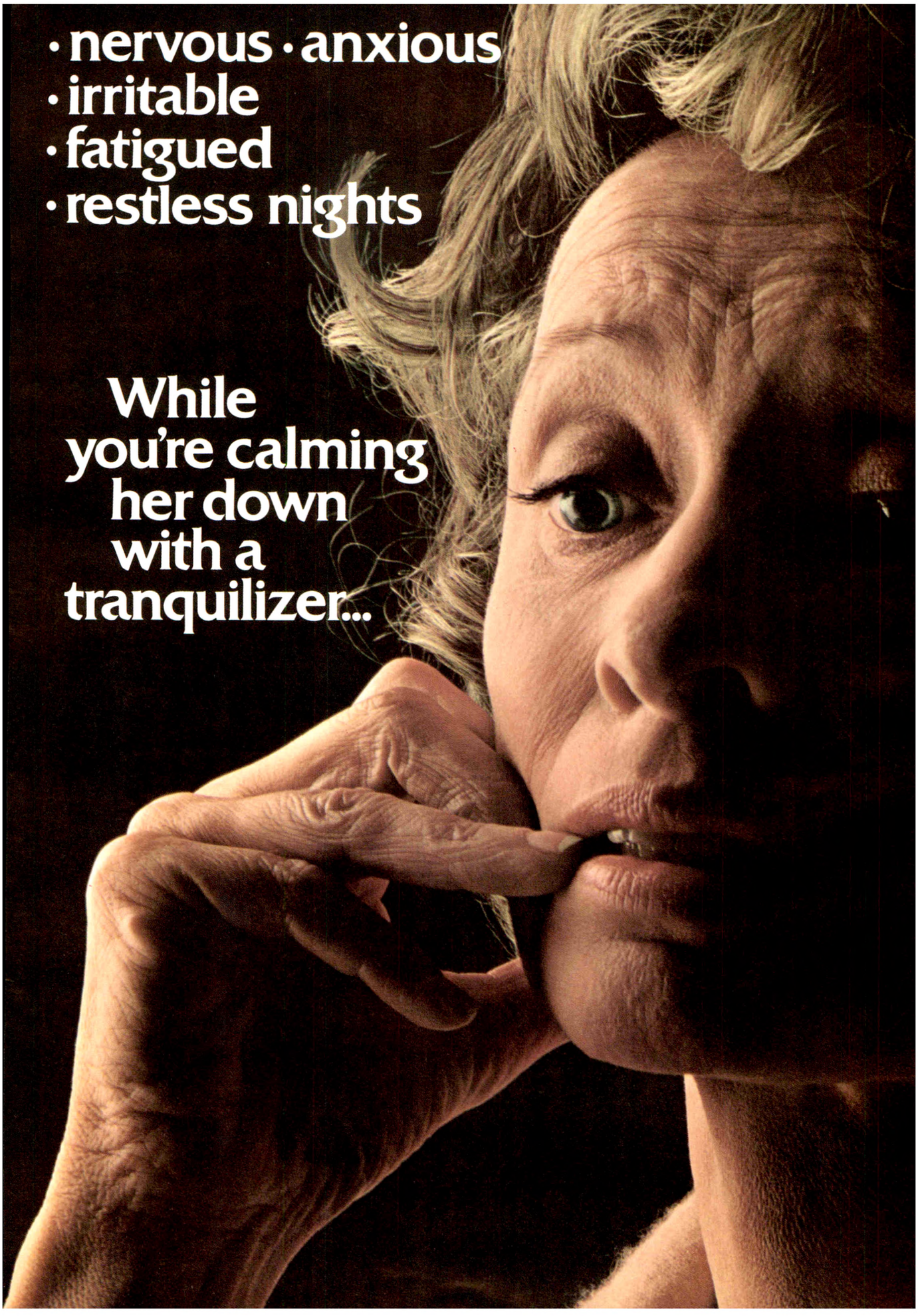

Focus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS



Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707


· nervous · anxious
· irritable
· fatigued
· restless nights
While you're calming her down with a tranquilizer...

treat what may be her real problem with

PREMARIN® BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

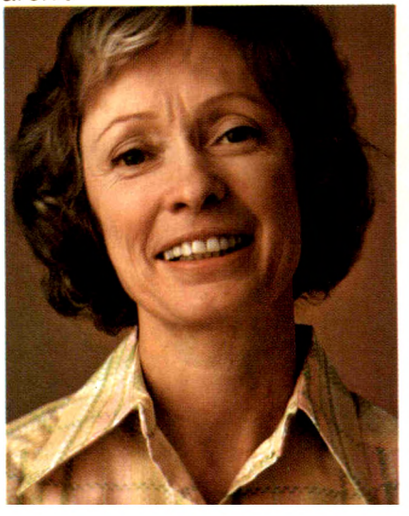
She's come to you in a highly emotional state, with complaints of anxiety, nervousness, insomnia, and depression. And treatment with a psychotherapeutic agent may be appropriate for immediate relief of symptoms.

But considering her age, and her irregular menses, such symptoms may indicate an underlying estrogen deficiency... and the need for additional, more comprehensive therapy.

PREMARIN, by offering sound specific natural estrogen replacement, can provide such therapy ...relieve estrogen-related emotional symptoms of the menopause by treating their cause. Anxiety and depression related to estrogen deficiency usually respond to replacement therapy in a relatively short time.[1,2] Other "psychogenic" symptoms such as headaches, crying spells, insomnia, feelings of weakness and fatigue may also be relieved.[1,3-5]

And in a large majority of patients, PREMARIN imparts a renewed sense of well-being.[6] At the same time, PREMARIN helps control hot flushes, sweats, genital tissue atrophy, and, in selected cases, helps retard postmenopausal osteoporotic bone degeneration.*

When there is uncertainty as to the origin of emotional symptoms in the menopausal woman, a therapeutic trial with PREMARIN helps relieve those complaints that are estrogen-related...while helping to identify those that aren't.[7]



for estrogen-related emotional symptoms of the menopause

See last page of advertisement for prescribing information.

*Conjugated Estrogens Tablets have been evaluated as "probably" effective for postmenopausal osteoporosis.

when her real problem is estrogen deficiency



PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)
contains only natural estrogens

for estrogen-related emotional symptoms

BRIEF SUMMARY
(For full prescribing information, see package circular.)

PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding
(See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manife

Dosage and Administration: PREMARIN shoul be administered cyclically (3 weeks of daily estr gen and 1 week off) for all indications ex cept selected cases of carcinoma and preventio of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cycl cally. Adjust dosage upward or downwar according to severity of symptoms and respons of the patient. For maintenance, adjust dosage t lowest level that will provide effective control.

If the patient has not menstruated within th last two months or more, cyclic administration started arbitrarily. If the patient is menstruating cyclic administration is started on day 5 of bleed ing. If breakthrough bleeding (bleeding or spo ting during estrogen therapy) occurs, increas estrogen dosage as needed to stop bleeding. I the following cycle, employ the dosage level use to stop breakthrough bleeding in the previou cycle. In subsequent cycles, the estrogen dosag is gradually reduced to the lowest level which w maintain the patient symptom-free.

Postmenopause—as a protective measur against estrogen deficiency-induced degenera tive changes (*e.g.* osteoporosis, atrophic vag nitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. dail and cyclically. Adjust dosage to lowest effectiv level.

Osteoporosis (to retard progression)—usua dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or with out Pruritus—0.3 mg. to 1.25 mg. or more dail depending upon the tissue response of the ind vidual patient. Administer cyclically.

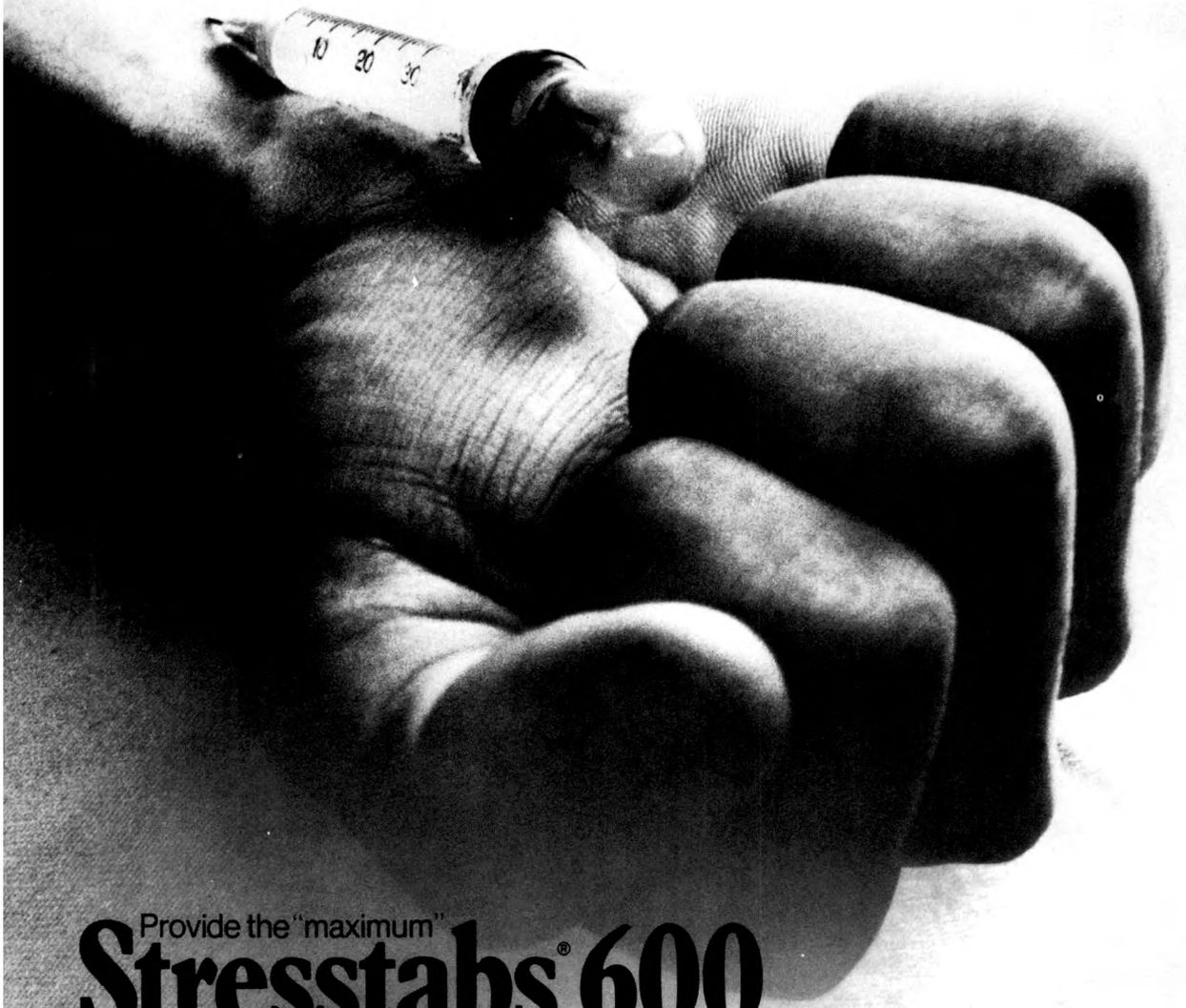
How Supplied: PREMARIN (Conjugated Estrc gens Tablets, U.S.P.) No. 865—Each *purple* tabl contains 2.5 mg., in bottles of 100 and 1,00(No. 866—Each *yellow* tablet contains 1.25 mg in bottles of 100 and 1,000. Also in unit dose pacl age of 100. No. 867—Each *red* tablet contain 0.625 mg., in bottles of 100 and 1,000. No. 868- Each *green* tablet contains 0.3 mg., in bottles c 100 and 1,000.

References: 1. Kerr, M.D.: Mod. Treatm. *5*:58 (May) 1968. 2. Penningroth, R.P., and Tourne G.: Postgrad. Med. *46*:118 (July) 1969. 3 Rhoades, F.P.: J. Amer. Geriat. Soc. *15*:346 (Apr 1967. 4. Astwood, E.B., in Goodman, L.S., an Gilman, A. (Eds.): The Pharmacological Basis c Therapeutics, ed. 4, New York, The Macmilla Company, 1970, chap. 69, p. 1538 ff. 5. Kuppe man, H.S.: Med. Aspects of Hum. Sexuality *1*:6 (Sept.) 1967. 6. Tramont, C.B.: Geriatrics *21*:21 (Nov.) 1966. 7. Kaufman, S.A., in Sturgis S.H., and Taymore, M. (Eds.): Progress in Gyne cology, New York, Grune & Stratton, Inc., 197(vol. 5, p. 179.

Ayerst AYERST LABORATORIES
New York, N.Y. 10017

734

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

High Potency Stress Formula Vitamins

Each Tablet Contains:

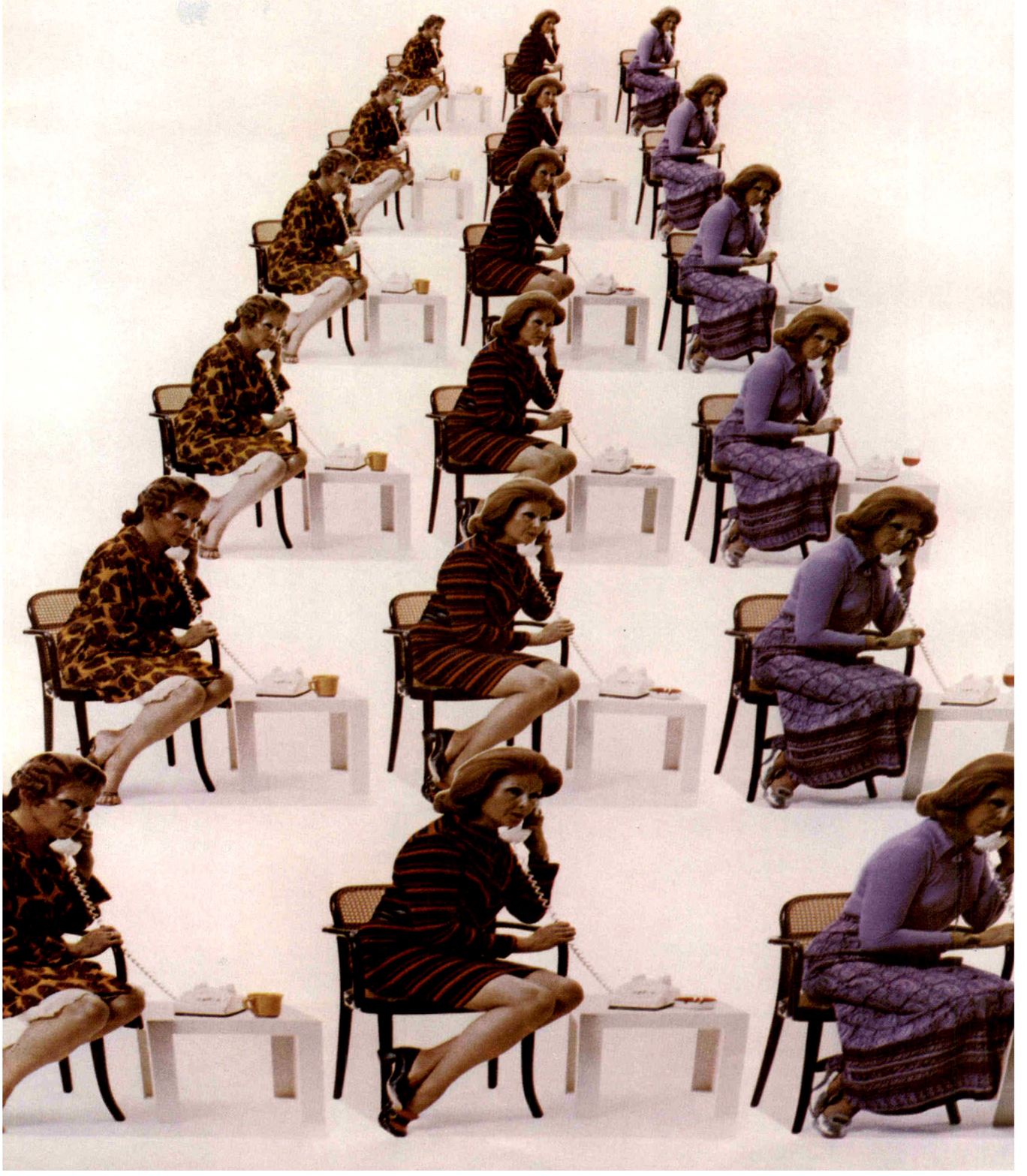
Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3

If she calls you morning...noon...and night

day after day after day



To allay her chronic neurotic anxiety* try her on

Stelazine®

brand of **trifluoperazine HCl** **2 mg. tablets**

Excessive use of the telephone is often symptomatic of chronic neurotic anxiety. Because such patients are often immune to lasting reassurance, in addition to your counsel, supportive medication may be helpful.

For such patients, 'Stelazine' is often a wise choice. Its anti-anxiety action is usually free from excessive drowsiness. The recommended b.i.d. dosage is convenient and economical. And dependence and withdrawal symptoms have not been reported with 'Stelazine' therapy.

* 'Stelazine' has been evaluated as possibly effective for this indication. See Brief Summary.

Before prescribing, see complete prescribing information, including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

* **Indications**

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, pancytopenia, anemia, cholestatic jaundice, liver damage have been reported.

Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 1 mg., 2 mg., 5 mg. and 10 mg., in bottles of 100; Injection, 2 mg./ml.; and Concentrate, 10 mg./ml.

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630, under Stelazine® trademark license from SmithKline Corporation, Philadelphia, Pa.

R.S.V.P.



She just doesn't respond to things. No interest. No energy. Discouraged.

It may be mild depression. She needs help...and she needs it now.

Counsel and reassurance may suffice. But if you decide supportive medication is indicated, Ritalin can offer prompt benefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
(methylphenidate)
helps the patient respond in mild depression*

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available.
Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary.
Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported.
Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901 2/4753-1 17

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

CIBA

VALIUM®
(diazepam)
IN THE CONTEXT OF CRISIS THERAPY FOR INTENSE ANXIETY

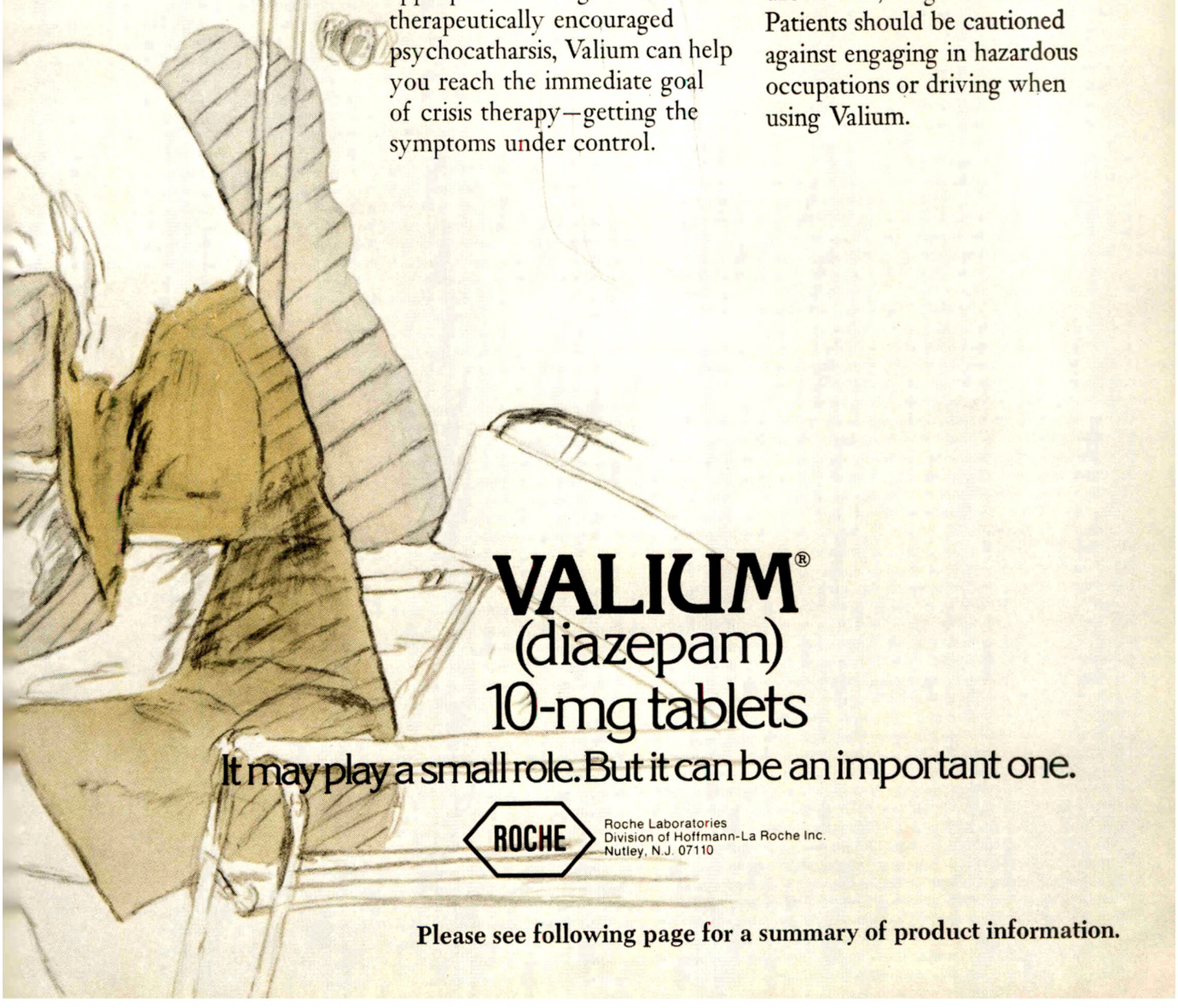


Covert conflicts may provoke an emotional state of emergency in the patient under long-term analysis. When the patient feels overwhelmed and threatened by his inability to resolve the conflict at hand, psychic tension and anxiety are likely to become excessive. At this critical time, he needs the immediate emotional support of crisis therapy. Your human responsiveness and empathy provide the patient with the necessary framework within which he can stabilize his emotional equilibrium. The calming effect of Valium (diazepam) may be useful along with crisis therapy to help the patient gain a measure of control over the situation.

Of course, emotional crises in this patient may also be stimulated by an extremely stressful event such as bereavement, divorce, financial disaster or natural catastrophe. Crisis therapy offers immediate measures when individuals cannot manage their reaction to powerful emotional stress. When psychic tension and anxiety are excessive, the adjunctive use of Valium (diazepam) may also be appropriate. Along with therapeutically encouraged psychocatharsis, Valium can help you reach the immediate goal of crisis therapy—getting the symptoms under control.

Although the role of Valium (diazepam) may be small in helping the individual in crisis, it can be significant. Valium 10 mg *t.i.d.* can provide prompt, effective action to reduce intense psychic tension and anxiety resulting from overreaction to severe stress. When the symptomatology has been sufficiently modified, Valium may be discontinued or the dosage adjusted with the 2-mg or 5-mg tablets *t.i.d.* or *q.i.d.*

Valium is generally well tolerated in the usual dosage range. The most frequently reported side effects have been drowsiness, fatigue and ataxia. Patients should be cautioned against engaging in hazardous occupations or driving when using Valium.



VALIUM®
(diazepam)
10-mg tablets

It may play a small role. But it can be an important one.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Please see following page for a summary of product information.

VALIUM®
(diazepam)
10-mg tablets



In the context of crisis therapy, helps reduce intense anxiety and tension.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

SPRINGER

ACTING-IN

Practical Applications of Psychodramatic Methods

Howard A. Blatner, M.D. Foreword by J. L. Moreno, M.D. Psychodrama—as a means of helping a person enact, rather than talk about his problems—is one of the more effective tools of psychotherapy. This book presents the theory of psychodrama and discusses its use with children, in industry, in professional training, and other areas. With a complete biography of J. L. Moreno. *176 pages, $5.25*

AGING AND BEHAVIOR

Jack Botwinick, Ph.D. Up-to-date, comprehensive study of the literature on the "psychology of aging." Main topics include: Who are the aged? Factors in longevity and survival: biological, environmental, psychological, social. Sexuality and sexual relations. Turning inward. Rigidity. Cautious behavior. Processing sense information. Intelligence. Problem solving. Learning and performance. Memory theory. Operational and conceptual issues in research. *336 pages, $10.50*

SUICIDE INTERVENTION

Sheila A. Fisher, Ph.D. Experience-based guide for operating suicide prevention and/or crisis telephone centers—including details of sponsorship, funding, staffing, training recruits, community liaison, and follow-up services. Extensive appendices include samples of worksheets, publicity, a training manual, and other useful forms. *285 pages, $6.95*

Structured and Scaled Interview to Assess Maladjustment (SSIAM)

Barry J. Gurland, *Biometrics Research, New York State Dept. of Mental Health*

Neil J. Yorkston, *Health Sciences Center, University of Minnesota*

Anthony R. Stone and **Jerome B. Frank**—both of *Psychotherapy Research Unit, Henry Phipps Clinic, Johns Hopkins*

A tested instrument by which an interviewer can identify problems in social adjustment and rate them quantitatively. The half-hour interview includes forty-five questions, covering work, social life, family, marriage and sexual adjustment. SSIAM is well suited for research comparisons of groups, or for defining target areas and for following progress in treatment of the individual patient. Each 32-page copy includes interview, scales, profile chart, and instructions for administering and rating the interview. *10 copies, $20.00; 3 sample copies, $6.50*

Send for the complete descriptive list of Springer psychological tests. Write:

SPRINGER PUBLISHING COMPANY, INC., 200 PARK AVENUE SOUTH, NEW YORK, N. Y. 10003

CHESTNUT LODGE

DEXTER M. BULLARD, JR., M.D.
Medical Director

DEXTER M. BULLARD, SR., M.D.
Senior Consultant

JOHN P. FORT, M.D.
Clinical Director

PING-NIE PAO, M.D.
Director of Psychotherapy

EDWARD M. PODVOLL, M.D.
Director of Admissions

JOHN L. CAMERON, M.D.
Director of Research

ASSOCIATES

JAIME BUENAVENTURA, M.D.
DAVID B. FEINSILVER, M.D.
LEA GOLDBERG, M.D.
WILLIAM N. GOLDSTEIN, M.D.
ROBERT GRUBER, M.D.
MILTON G. HENDLICH, M.D.
SOL HERMAN, M.D.
PHILIP R. HERSCHELMAN, M.D.
DAVID W. HERSHEY, M.D.
ERICH HEYDT, M.D.
MARGARET A. JOLLY, M.D.
ROBERT I. KURTZ, M.D.
JOHN W. R.-LOVE, M.D.
CARL I. MARGOLIS, M.D.
DAVID N. RATNAVALE, M.D.
JAMES O. REDDING, M.D.
MANUEL ROSS, M.D.
JONATHAN D. TUERK, M.D.
SAMUEL V. THOMPSON, M.D.

CLINICAL PSYCHOLOGIST
REBECCA RIEGER, Ph.D.

ATTENDING INTERNISTS
CORINNE COOPER, M.D.
G. BOWDITCH HUNTER, JR., M.D.

ROCKVILLE MARYLAND

A new publication from

THE JOINT INFORMATION SERVICE
of the American Psychiatric Association
and the National Association for Mental Health

MENTAL HEALTH ON THE CAMPUS

By Raymond M. Glasscote
Michael E. Fishman
Clifford B. Reifler
James Raybin
Floyd D. Turner
Bernard L. Bloom
Samuel Pearlman
E. Robert Sinnett

". . . A most significant, objective explication of campus mental health. I endorse it wholeheartedly."
—Dana Farnsworth

During the 1960's, that portion of the college-age population who were actually enrolled in colleges increased by 41 percent. During that same time more than 500 new colleges and universities were created, so that fully one fifth of all the country's institutions of higher learning in 1970 had come into being during the previous decade. Many of these new schools—as well as many longer-established ones—appeared to be providing little if anything in the way of formal support services for students who undergo any form of emotional or behavioral crisis. With the hope of stimulating interest in creating such support services, the Joint Information Service undertook to survey the numerous helping resources being provided at a selected group of colleges of widely varying characteristics. To do so it enlisted the talents of several of the most distinguished and accomplished practitioners in university mental health services. After extensive investigation, six schools outstanding for their mental health networks, plus a unique facility that contracts psychiatric treatment and consultation to more than a score of schools, were chosen for intensive study. Each program was visited in 1971 and 1972 by the authors and their collaborators, who interviewed not only the staff of the formal mental health services but representatives of the administration, housing, religious and many other kinds of activities and programs, faculty members, student leaders, and students who had utilized the mental health services. Consistently the interviews revealed some startling changes in campus interests and values during the year or two preceding the visits. Along with a substantial decline of political and social activism, a remarkable increase in religiosity was manifest, with church attendance markedly higher and "the Jesus Freak movement," in the opinion of one student leader, becoming the most significant new development on the campus. There was a significant resurgence of interest in academics and vocational planning, and considerable concern about postcollege employment prospects. In response to student demands, most of the schools had added seminars and lectures on marriage preparation and sexuality, with the result, at one school, of an almost ninety percent reduction in unplanned pregnancies. There was various tentative evidence that on the one hand drug usage, overall, had passed its peak, but on the other that marijuana use had been considerably incorporated into the social fabric of most of the schools.

Beyond these observations of broad change, the volume describes many specific services which were felt in some manner to support and enhance the emotional well-being of students—for example, advance orientation programs held for new students during the summer prior to their admission; small counseling groups led by mental health and housing personnel and faculty members which meet throughout the freshman year; special programs and services for married students; use of specially trained upperclassmen as "student-to-student" counselors for those concerned about sexually oriented and socially oriented issues; tutorial and counseling programs for students from minority groups; and abortion counseling. There are detailed descriptions of the formal mental health services, including various approaches to individual and group treatment, medication, and provisions for hospitalization.

These and many other aspects of the emotional life of the campus are discussed in this volume, both in an overview of the contemporary college scene in America, and in detailed individual descriptions of the schools with their impressive range of supporting services.

216 pp. casebound $7.00

Please send me _____ copy(ies) of **Mental Health on the Campus,** Order #202, @ $7.00 ea. (four or more copies, $6.00 ea., eight or more copies, $5.00 ea.)

☐ Bill Me ☐ Check Enclosed

Send Coupon to:

American Psychiatric Association
Publications Sales
1700 Eighteenth St., N.W.
Washington, D.C. 20009

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

873AJP



Book dealers and wholesalers. 40% discount on orders of 5 or more copies. 50% discount on orders of 25 or more copies.

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director
OSCAR ROZETT, M.D., Medical Administrator
GRANVILLE L. JONES, M.D., Director of Research
FELIX A. UCKO, M.D., Chief, Adolescent Program
MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning in humans. Animal studies have shown that physostigmine also reverses certain toxic effects of protriptyline, but to a lesser extent.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

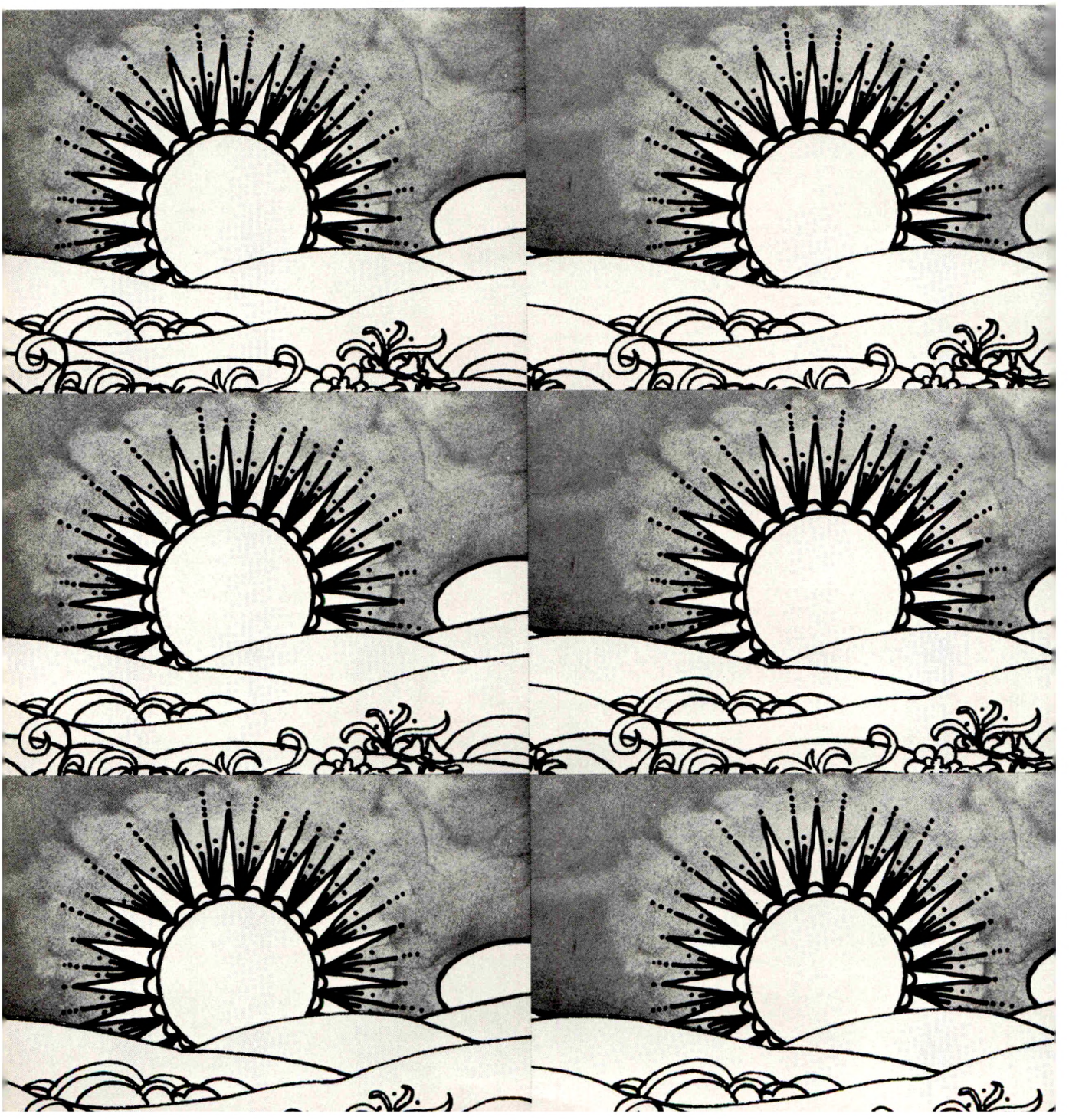
In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

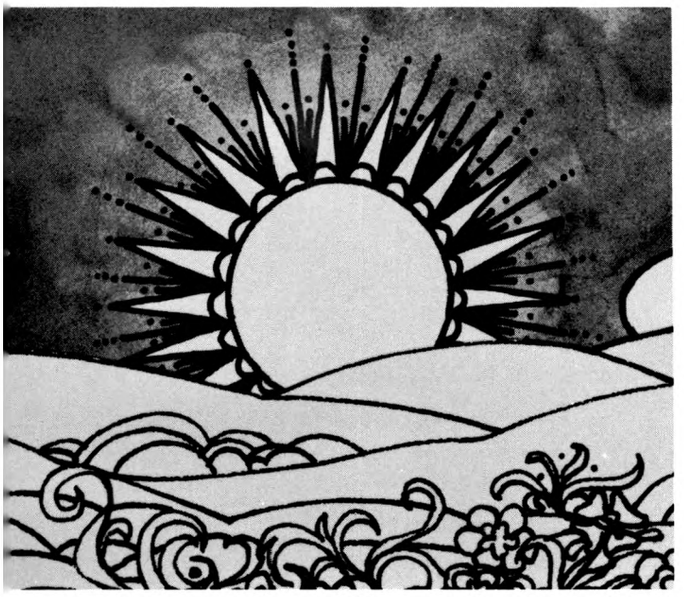
When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

The new-day constant for drug-induced parkinsonism:



ARTANE®
TRIHEXYPHENIDYL HCl
Non-cumulative action makes each day of therapy a new day



That's why ARTANE is ideally suited for the patient on long-term phenothiazine therapy. In economical tablets or SEQUELS Sustained Release Capsules*, it offers you *more* than the rapid reversal of extrapyramidal symptoms.

Usually there is no drug buildup to cause undue toxicity in prolonged therapy. Minimal atropine-like side effects. Accurate dosage titration in adjunctive use. And, to minimize missed doses and anxiety in outpatient therapy— one-dose *all-day* control or prevention with SEQUELS.*

For hospitalized or ambulatory patients, ARTANE has the "constant" they need. Effective *non-cumulative* action.

Tablets—2 mg, 5 mg; Elixir†—2 mg/5 cc or SEQUELS® Sustained Release Capsules—5 mg.

Tablets and Elixir Indications: FDA has evaluated this drug as Effective as an adjunct in the therapy of the indications listed below under SEQUELS.

***INDICATIONS FOR ARTANE SEQUELS:**
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms of parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine and phenothiazines.

WARNING:
Patients to be treated should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache.

†Lime-mint flavored, with 0.08% methylparaben, 0.02% propylparaben, and 5% alcohol as preservatives.

*This drug in sustained release form has been evaluated as probably effective. See Brief Summary.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

716-3

For the psychiatrist

The documented properties of DALMANE® (flurazepam HCl) for sleep

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

The properties of Dalmane have been carefully defined and thoroughly evaluated. Results of these investigations—many of which are cited here—have documented the effectiveness and relative safety of Dalmane when the etiology of insomnia indicates need for sleep medication.

Prompt sleep induction, effective through the night[1-13]

Consistently effective night after night[2,3,5,6,8-13]

Relative safety[11,14,15*]

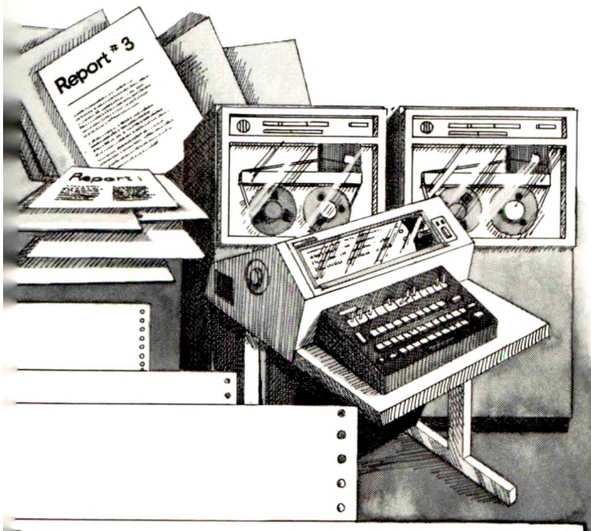
Usefulness in chronically anticoagulated patients[11]

1. Kales, A.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Philadelphia, Lippincott, 1969, p. 331. **2.** Kales, J., *et al.: Clin. Pharmacol. Ther., 12*:691, 1971. **3.** Jacobson, A., *et al.: Psychophysiology, 7*:345, 1970. **4.** Kales, A., and Kales, J.: *J.A.M.A., 213*:2229, 1970. **5.** Frost, J. D., Jr.: "A Sys for Automatically Analyzing Sleep," Scientific Exhibit sented at Clinical Convention, A.M.A., Boston, Nov. Dec. 2, 1970; and at 42nd Annual Scientific Meet Aerospace Med. Assoc., Houston, April 26-29, 1 **6.** Karacan, I., *et al.:* "The Sleep Laboratory in the Inv gation of Sleep and Sleep Disturbances," Scier Exhibit presented at Amer. Psychiat. Assoc., Washing D.C., May 3-7, 1971. **7.** Hartmann, E.: *Psychophar cologia (Berl.), 12*:346, 1968. **8.** Dement, W. C.: Dat file, Medical Department, Hoffmann-La Roche Nutley, N.J. **9.** Vogel, G. W.: Data on file, Medical Dep ment, Hoffmann-La Roche Inc., Nutley, N.J. **10.** Kales and Kales, J. D.: *Pharmacol. Physicians, 4*:1, 1 **11.** Data on file, Medical Department, Hoffmann-La Ro Inc., Nutley, N.J. **12.** Kales, A., *et al.: Arch. Gen. Psyc 23*:226, 1970. **13.** Meyer, J. A.: "Flurazepam Hydroc ide for the Short-Term Treatment of Insomnia in

*Generally, when adverse effects were reported clinically with Dalmane (flurazepam HCl), they were mild and infrequent. Dizziness, drowsines lightheadedness and the like were the side effects noted most often, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 m should be prescribed for these patients.)

ttle "hang-over" effect on vakening[11,14]

spitalized Post-Surgical Patient," Scientific Exhibit sented at AAGP, San Francisco, Calif., Sept. 28-Oct. 970. **14.** Zimmerman, A. M.: *Curr. Ther. Res., 13*:18, 71. **15.** Greenblatt, D., and Shader, R.: *Ann. Intern. d., 77*:91, 1972.



Data about Dalmane (flurazepam HCl) on request

The references cited constitute only a part of the Dalmane bibliography. Additional data are available through the Roche Professional Services Department. Augmenting this service is RETRIEVE, a computer-operated data retrieval system which screens data from the published English language papers on Dalmane to help provide rapid answers to your specific questions. Coded into the computerized index are parameters that include patient age, sex, condition; product dose, side effect, frequency of administration; other medications or therapy; length, type and size of study, and pharmacology.

For specific answers to any questions you might have about Dalmane, write or call: Roche Professional Services Department, Roche Laboratories, Nutley, N.J. 07110. Telephone: (201) 235-2355.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MOVING?

PLEASE NOTIFY US 6 WEEKS IN ADVANCE

Change of address or name for THE AMERICAN JOURNAL OF PSYCHIATRY and/or PSYCHIATRIC NEWS. Please use only one address for APA mailings. Thank you.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS OR NAME:
(The number of characters indicated include spaces.)

APA IDENTIFICATION NO. (6 characters)

NAME: (24 characters)

(last) (first) (middle initial)

STREET ADDRESS: line #1 (24 characters)

STREET ADDRESS: line #2 (24 characters)

CITY: (16 characters)

STATE: (2 characters)

ZIP: (7 characters)

MAIL TO:

Division of Manpower Research
and Development
AMERICAN PSYCHIATRIC ASSOCIATION
1700 Eighteenth St., N.W.
Washington, D. C. 20009

INDEX TO ADVERTISERS

August 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

AYERST
Premarin A36–A38

CIBA PHARMACEUTICAL COMPANY
Ritalin A42–A43
Ritalin MBD A12–A13

DEVEREUX FOUNDATION C4

JOHNS HOPKINS UNIV. PRESS A11

KNOLL PHARMACEUTICAL
Akineton A27

LAKESIDE LABORATORIES
Norpramin A58–C3

LEDERLE
Artane A52–A53
Stresstabs A39

McNEIL LABORATORIES, INC.
Haldol A9–A10

MERCK SHARP & DOHME
Elavil A22–A24
Triavil A30–A33
Vivactil A50–A51

MENNINGER FOUNDATION A25

REUBEN REITER, ScD. INC.
Electrostimulators A17

ROCHE LABORATORIES
Dalmane A54–A55
Librium A28–A29
Valium A44–A46

SANDOZ
Mellaril A26
Serentil A14–A16

SANITARIUMS AND PRIVATE HOSPITALS ... A49, A47

W. B. SAUNDERS COMPANY A11

SMITH KLINE AND FRENCH LABORATORIES
Stelazine A40–A41
Thorazine C2

SPRINGER PUBLISHING CO., INC. A47

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A6–A8

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A21
Pertofrane A34–A35

WYETH LABORATORIES
Serax A18–A20

Mental Illness in Later Life

by Ewald W. Busse, M.D.
Eric Pfeiffer, M.D.

A comprehensive, practical guide for the practicing physician about the emotional problems of the aged patient. Included are pragmatic suggestions for interviewing, diagnosis, treatment, and supportive care, with consideration of social, cultural, and psychological factors. A special *Question-and-Answer* section is a valuable supplement.

"The 12 well written chapters of this book, all by knowledgeable investigators in the field of geriatric mental illness, offer both an overall review of the current status of the field and more detailed information on such specialized topics as the demography of aging, the epidemiology of geriatric mental disorder, diagnostic procedures of the evaluation of brain impairment, social and psychological aspects of mental illness in the aged, insurance coverage for mental illness in later life, organic and functional geriatric mental disorders, physical changes with aging and their relationship to mental functioning, and institutional and ambulatory treatment of the aged mentally ill. The content and approach make the volume appropriate and useful reading both for psychiatrists, who have paid too little attention to the psychiatric problems of the aged, and for social workers, psychologists, nurses, and other personnel who deal with the elderly mentally ill. Pragmatic suggestions are made for interviewing, diagnosis, treatment, and supportive care, and there is adequate emphasis on social, psychologic, and cultural factors. The Question and Answer *section of the book is an especially valuable supplement, especially to readers whose interest is primarily pragmatic."*

ALEXANDER SIMON, M.D.
Professor and Chairman
Department of Psychiatry,
University of California, School of Medicine, San Francisco

308 pages — $7.00 for paperback/$9.00 for case-bound

Please send me _____ copy(ies) of **Mental Illness in Later Life.**

_____ Paperback @ $7.00 ea. (order # 188)

_____ Case-bound @ $9.00 ea. (order # 188-1)

(Please Print) ☐ Bill Me ☐ Check Enclosed

Name _____

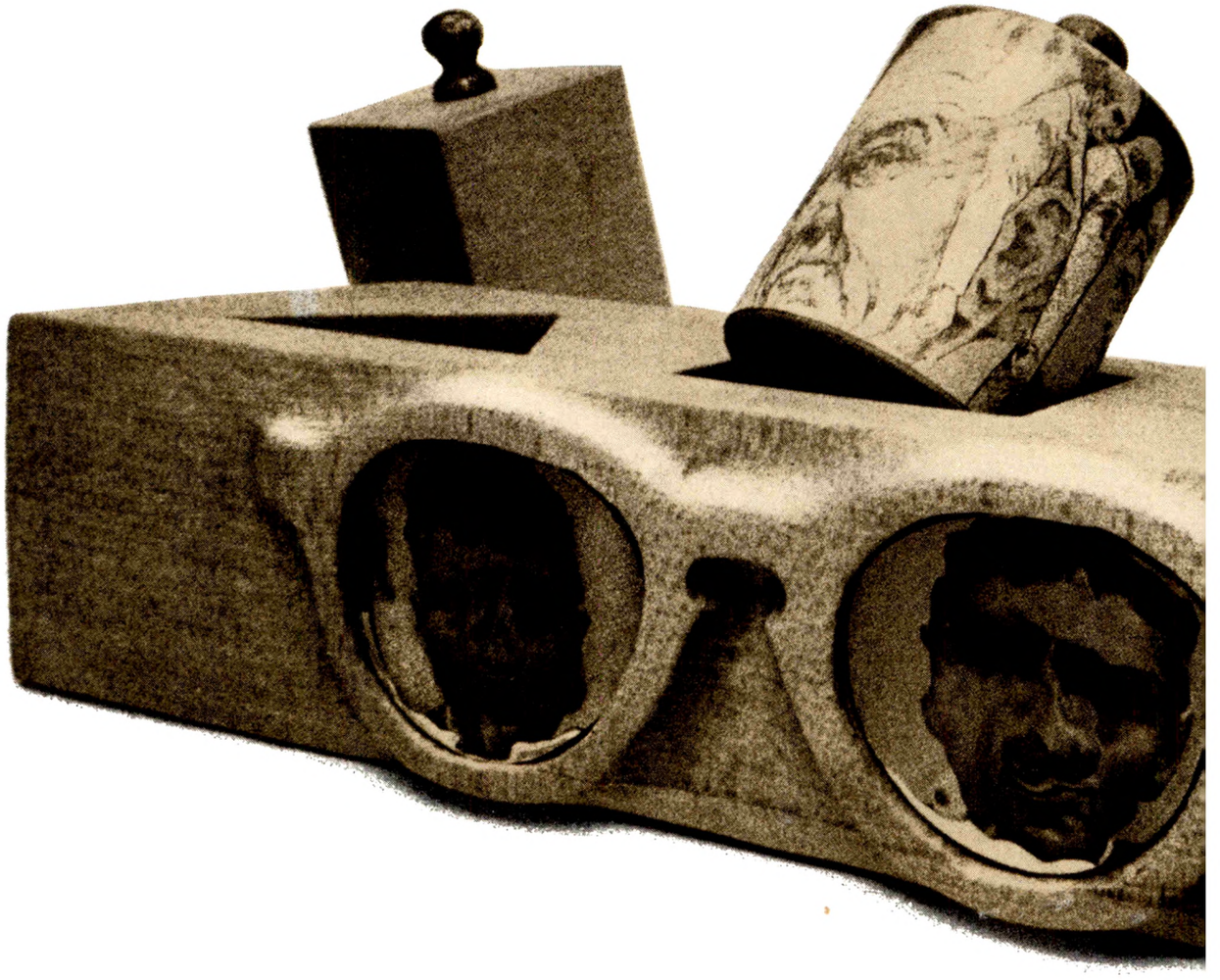
Address _____

City _____ State _____ Zip _____

Send Coupon to: **American Psychiatric Association**
Publications Sales
1700 Eighteenth St., N.W.
Washington, D.C. 20009

873AJP

H lp im,rov you. d ,r d patients' ability to cope.



In Brief:

Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.

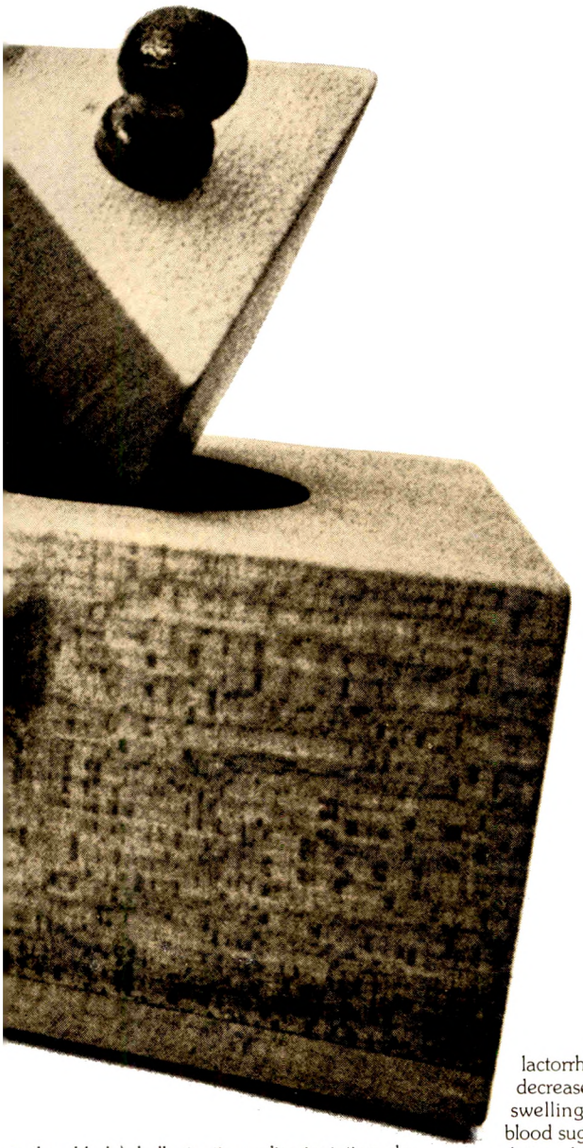
Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosis i schizophrenic patients. Close supervision an careful adjustment of dosage are required whe this drug is given along with anticholinergic c sympathomimetic drugs. While taking this drug response to alcoholic beverages may be exagge ated. There is limited clinical experience in th concurrent administration of ECT and antide pressant drugs; thus, one should consider th possibility of increased risk relative to benefit Discontinue as soon as possible prior to electiv surgery because of possible cardiovascula effects. Hypertensive episodes have bee observed during surgery in patients on desipra mine hydrochloride. Leukocyte and differentia counts should be performed in any patient wh develops fever and sore throat during therapy the drug should be discontinued if there is neu tropenia.

Adverse Reactions: *Cardiovascular:* hypoten sion, hypertension, tachycardia, palpitation arrhythmias, heart block, myocardial infarction stroke. *Psychiatric:* confusional states (especially



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

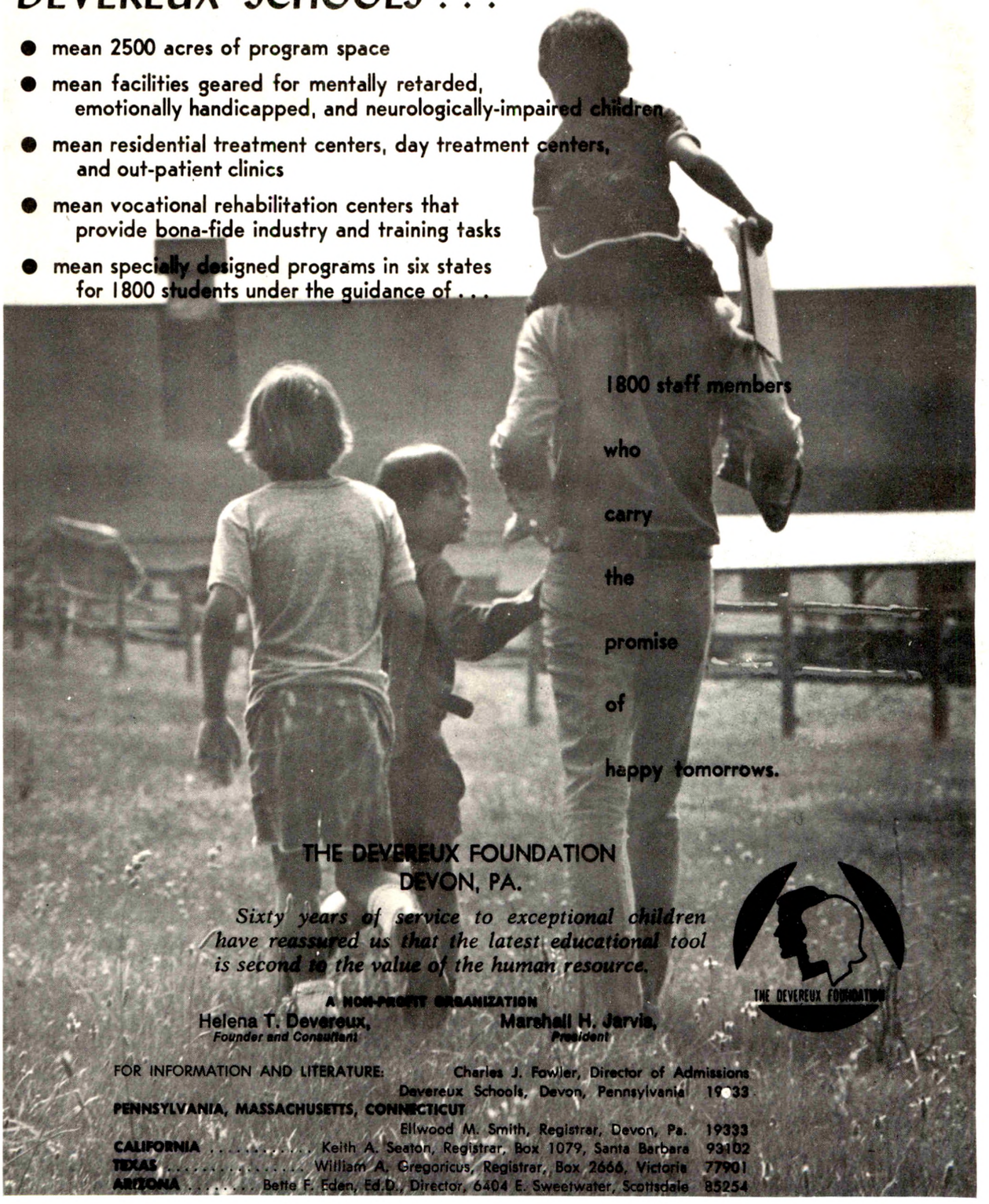
How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.*, sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.*, sugar coated tablets, light green, in bottles of 50. 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

DEVEREUX SCHOOLS . . .

- mean 2500 acres of program space
- mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impaired children
- mean residential treatment centers, day treatment centers, and out-patient clinics
- mean vocational rehabilitation centers that provide bona-fide industry and training tasks
- mean specially designed programs in six states for 1800 students under the guidance of . . .



1800 staff members who carry the promise of happy tomorrows.

THE DEVEREUX FOUNDATION
DEVON, PA.

Sixty years of service to exceptional children have reassured us that the latest educational tool is second to the value of the human resource.

THE DEVEREUX FOUNDATION

A NON-PROFIT ORGANIZATION

Helena T. Devereux, *Founder and Consultant*

Marshall H. Jarvis, *President*

FOR INFORMATION AND LITERATURE: Charles J. Fowler, Director of Admissions, Devereux Schools, Devon, Pennsylvania 19333

PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT Ellwood M. Smith, Registrar, Devon, Pa. 19333

CALIFORNIA . . . . . Keith A. Seaton, Registrar, Box 1079, Santa Barbara 93102

TEXAS . . . . . William A. Gregoricus, Registrar, Box 2666, Victoria 77901

ARIZONA . . . . . Bette F. Eden, Ed.D., Director, 6404 E. Sweetwater, Scottsdale 85254

Vol. 130, No. 9 September 1973

THE AMERICAN JOURNAL OF PSYCHIATRY

Overview Article

Bartolucci and Drayer on Crisis Intervention

Also in this issue

Medical Ethics: Applications to Psychiatry

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Thorazine® offers you a choice.

brand of **chlorpromazine**

18 Dosage Forms and Strengths

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.

Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.

Injection, 25 mg./ml.

Syrup, 10 mg./5 ml.

Suppositories, 25 mg. and 100 mg.

Concentrate, 30 mg./ml. and 100 mg./ml.



SK&F Smith Kline & French Laboratories, Philadelphia



THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

The American Journal of Psychiatry, formerly *The American Journal of Insanity*, is published monthly by the American Psychiatric Association. Editorial office: 1700 Eighteenth Street, N.W., Washington, D.C. 20009; telephone (202) 232-7878.

Subscriptions: U.S. $15.00 per year, Canada and South America $15.75, other foreign $18.00; single issues: $1.75 plus postage.

APA members should direct changes of address and communications about nonreceipt of the *Journal* to the Manpower Division, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

Communications from nonmember subscribers and all business communications should be directed to Mr. Robert J. Lowe, Publications Services Division, at the same address.

Advertising representatives: Steven K. Herlitz, Inc., 850 Third Avenue, New York, N.Y. 10022.

Type set by Bru-El Graphic, Inc., 5265 Port Royal Road, Springfield, Va. 22151.

Printed by Dartmouth Printing Co., 69 Lyme Road, Hanover, N.H. 03755.

Second class postage paid at Washington, D.C., and additional mailing offices.

Indexed in *Abstracts for Social Workers, Biological Abstracts, Chemical Abstracts, Cumulative Index to Nursing Literature, Excerpta Medica, Hospital Literature Index, Index Medicus, International Nursing Index, Nutrition Abstracts*, and *Psychological Abstracts*.

Copyright© 1973, the American Psychiatric Association.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers

Assistant Managing Editor
Amy E. Shaughnessy

Senior Assistant Editor
Linda A. Loy

Assistant Editors
Heidi A. Halter
Laura M. Little
James Johnson

Editorial Assistant
Katherine P. Olinick

Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.

UNIVERSITY COLLEGE OF MEDICINE
LIBRARY
C. U.

THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 9 September 1973

953 An Overview of Crisis Intervention in the Emergency Rooms of General Hospitals
Giampiero Bartolucci and Calvin S. Drayer

961 The Current Status of Systematic Desensitization
Joseph Wolpe, John Paul Brady, Michael Serber, W. Stewart Agras, and Robert Paul Liberman

966 Influence of Affective States and Psychoactive Drugs on Verbal Learning and Memory
George M. Henry, Herbert Weingartner, and Dennis L. Murphy

972 The Diagnostic Decision-Making Process: Factors Influencing Diagnosis and Changes in Diagnosis
David J. Fitzgibbons and Dean T. Hokanson

976 Engaging Heroin Addicts in Treatment
John A. Renner and Mark L. Rubin

981 Patterns of Professional Activities of Psychiatrists: A Follow-Up of 100 Psychiatric Residents
Floyd K. Garetz and Richard W. Anderson

985 Epidemiological Studies of Women Prisoners, I: Medical and Psychiatric Variables Related to Violent Behavior
Carlos E. Climent, Ann Rollins, Frank R. Ervin, and Robert Plutchik

991 Some Aspects of the History of Swiss Psychiatry
Manfred Bleuler

995 Suicidal Behavior in Edinburgh and Seattle
Herbert S. Ripley

1002 A Law Enforcement Training Program in a Mental Health Center Catchment Area
Edward J. Rolde, Ellsworth Fersch, Francis J. Kelly, Susan Frank, and Maurice Guberman

TOPICAL PAPERS: *Lithium*

1006 The Use of Lithium in Affective Disorders, III: A Double-Blind Study of Prophylaxis in Bipolar Illness
Frank Stallone, Edward Shelley, Julien Mendlewicz, and Ronald R. Fieve

1011 Relationship Between the Effectiveness of Lithium Therapy and Family History
Julien Mendlewicz, Ronald R. Fieve, and Frank Stallone

1014 Lithium-Induced Diabetes Insipidus: Manic Symptoms, Brain and Electrolyte Correlates, and Chlorothiazide Treatment
Steven T. Levy, John N. Forrest, Jr., and George R. Heninger

1018 Lithium-Induced Folliculitis
Arthur Rifkin, Stephen B. Kurtin, Frederic Quitkin, and Donald F. Klein

---

EDITORIAL

1020 Fewer Special Sections in the Offing
F.J.B.

BRIEF COMMUNICATIONS

1022 The Treatment of Depression with a Single Daily Dose of Imipramine Pamoate
J. Mendels and Joseph DiGiacomo

1024 Time-Extended Group Therapy Sessions in a Remote Setting
John Reckless, David Hawkins, and Alexandra Fauntleroy

1026 The Nonpsychotic Organic Brain Syndrome
Benjamin Feldshuh, Janet Sillen, Barbara Parker, and William Frosch

1029 The Effects of Social Prejudice on Hospitalized Adolescents
Paul G. Rossman and Derek Miller

1031 Personality Characteristics of Servicemen Returned from Viet Nam Identified as Heroin Abusers
Peter T. Hampton and Donald B. Vogel

1033 An Overview of a Psychiatric Clinic Population
Peter E. Sifneos

1036 Metapsychiatry: The Interface Between Psychiatry and Mysticism
Stanley R. Dean

1038 How Success Nearly Wrecked a Residency Experience
Frank M. Kline

1041 LETTERS TO THE EDITOR

1047 BOOK REVIEWS

OFFICIAL ACTIONS

1057 The Principles of Medical Ethics
With Annotations Especially Applicable to Psychiatry

A72 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of each a ticle: 60–100 words for regular articles, 40–60 words for Bri Communications. The author may prepare the precis himself c ask that the *Journal* staff prepare it, in which case the autho may make any necessary changes on the galley proofs.

References. References should be typed double-spaced on separate sheet of paper, to be attached at the end of the manu script. They should be arranged according to their order c appearance in the text, where they should be indicated b numbers in parentheses. Reference citations should be re stricted to closely pertinent papers; a complete review of th literature is rarely desirable, except in the case of review article for which a special arrangement has been made with the Editor

References should be typed in accordance with the styl shown below for books and journal articles; chapters in book will be treated as journal articles with regard to capitalization Up to three authors should be listed; one or more authors pas the third will be designated "et al." Abbreviations of journa names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxfor University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrin metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interaction between monoamine oxidase inhibitors and foodstuffs. Br J Psy chiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and figures should be sufficiently clear that the meaning of the data is understandable without reference to the text. See recent issues of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attached at the end of the manuscript. The data should be arranged so that columns of like material read down, not across.

A complete set of figures, preferably in the form of glossy prints, should accompany each of the two copies of the manuscript. Most figures will be reduced to about 3¼ inches in width, the column width of the *Journal*; all elements of a figure should be prepared to withstand this reduction. Graphs should be finished drawings not requiring further artwork. Authors are urged to engage the services of a professional in the preparation of figures. Authors may be required to meet the costs of any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for corrections after the paper has been scheduled for publication; prompt return (preferably within 48 hours of receipt) is necessary to ensure publication in the assigned month. If an author expects to be away from his office for a long period of time after he has received the acceptance letter, he should inform the *Journal* office or arrange with a colleague to read the proofs. Authors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the galley proofs submitted to authors for correction. Reprints are usually mailed to authors about a month after publication of the article. Requests from others to order reprints should be directed to the Editor; inclusion of a letter of permission from the senior author and a brief statement of the intended use of the reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG, HERBERT KLEMMER, ALAN A. STONE, PERRY C. TALKINGTON
For two years: EWALD W. BUSSE, HENRIETTE R. KLEIN, MELVIN SABSHIN, JOHN R. SAUNDERS
For one year: ROBERT S. GARBER, JOHN E. NARDINI, IRVING PHILIPS, CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN
Constitution and By-Laws
WINFRED OVERHOLSER, JR.
Ethics

Membership
ALEXANDER LEVINE
Nominating
HOWARD P. ROME
Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN
Academic Education
HAROLD MCPHEETERS
Drug Abuse and Drug Education
PETER BOURNE
School Consultation
SHELDON D. GLASS
Conference on Family Life Education
ARNOLD M. KALLEN
Certification in Administrative Psychiatry
ARCHIE R. FOLEY
History

Medical Education
HAROLD I. KAPLAN
Psychiatry and Medical Practice
ROBERT A. SENESCU
Continuing Education
JAMES NAIMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG
Transcultural Psychiatry
RAMON PARRES
Joint Meeting in Australia 1975
ALFRED AUERBACK
Psychiatry and Foreign Affairs
WILLIAM D. DAVIDSON
Inter-American Council of Psychiatric Associations
HOWARD P. ROME

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER
Women in Psychiatry
NANCY A. ROESKE *and* ELISSA P. BENEDECK
Psychiatric Involvement in Family Planning
EUGENE B. BRODY
Psychosurgery
JOHN DONNELLY

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE
Drug Abuse
DANIEL X. FREEDMAN
Nomenclature and Statistics
HENRY BRILL
Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION
Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER
Lithium Therapy
IRVIN M. COHEN
Meditation
JAMES MORGAN
Effects of Television on Mental Health
JAMES H. RYAN
Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS
Psychiatry and the Law
STANLEY L. PORTNOW
Liaison with American Hospital Association
GERALD R. CLARK
Liaison with American College of Physicians
CHARLES P. NEUMANN
Psychiatric Nursing
WILLIAM E. STONE
Interprofessional Relations
WILLIAM W. ZELLER
Right to Treatment
BERNARD DIAMOND
Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN
Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON
Financing of Mental Health Care
JOHN M. COTTON
Federal Government Health Services
STEWART BAKER
Childhood and Adolescence
VIOLA BERNARD
Private Psychiatric Hospitals
JOHN H. HOUCK
Suicide Prevention
MATHEW ROSS
Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD
APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON
Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE
Professional Standards Review Organizations
FRANK SULLIVAN

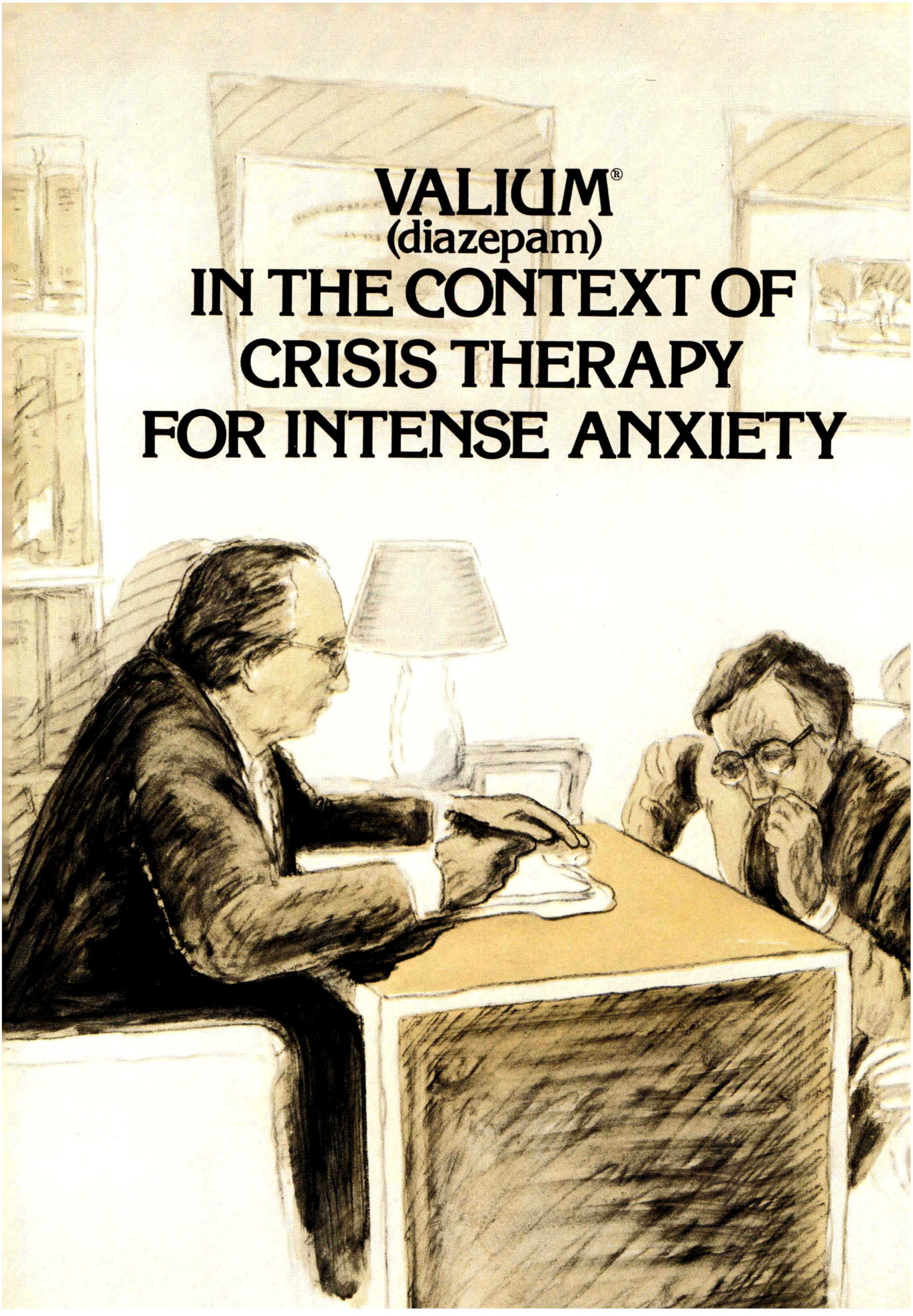
COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT
Program
H. KEITH H. BRODIE
Film Review
EDWARD A. MASON
Closed-Circuit TV Presentations
MILTON BERGER
Arrangements
BENJAMIN JEFFRIES
Conventions
ALEXANDER SIMON
Scientific Exhibits
ROBERT FROELICH
Awards for Scientific Exhibits
SARA DUBO
Public Information
JAMES P. CATTELL
Member Insurance and Retirement Plans
CHESTER TRENT
Trustees of APA Retirement Plan
SANFORD L. BILLET
House
DANIEL JAFFE
Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON
Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.
Isaac Ray Award
JOHN K. TORRENS
Manfred S. Guttmacher Award
JONAS R. RAPPEPORT
Hofheimer Prize
DONALD F. KLEIN
McGavin Award
NORBERT B. ENZER
Vestermark Prize
BERTRAM S. BROWN
Grants and Awards
JACK WEINBERG
Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL
Black Psychiatrists
JAMES P. COMER
Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT
Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ
Indian Affairs
MORTON BEISER
Comprehensive Health Planning
ROBERT L. WILLIAMS
Third-Party Intervention in Community Crises
FRANK OCHBERG
Legislative Network
HAYDEN H. DONAHUE

VALIUM®
(diazepam)
IN THE CONTEXT OF CRISIS THERAPY FOR INTENSE ANXIETY

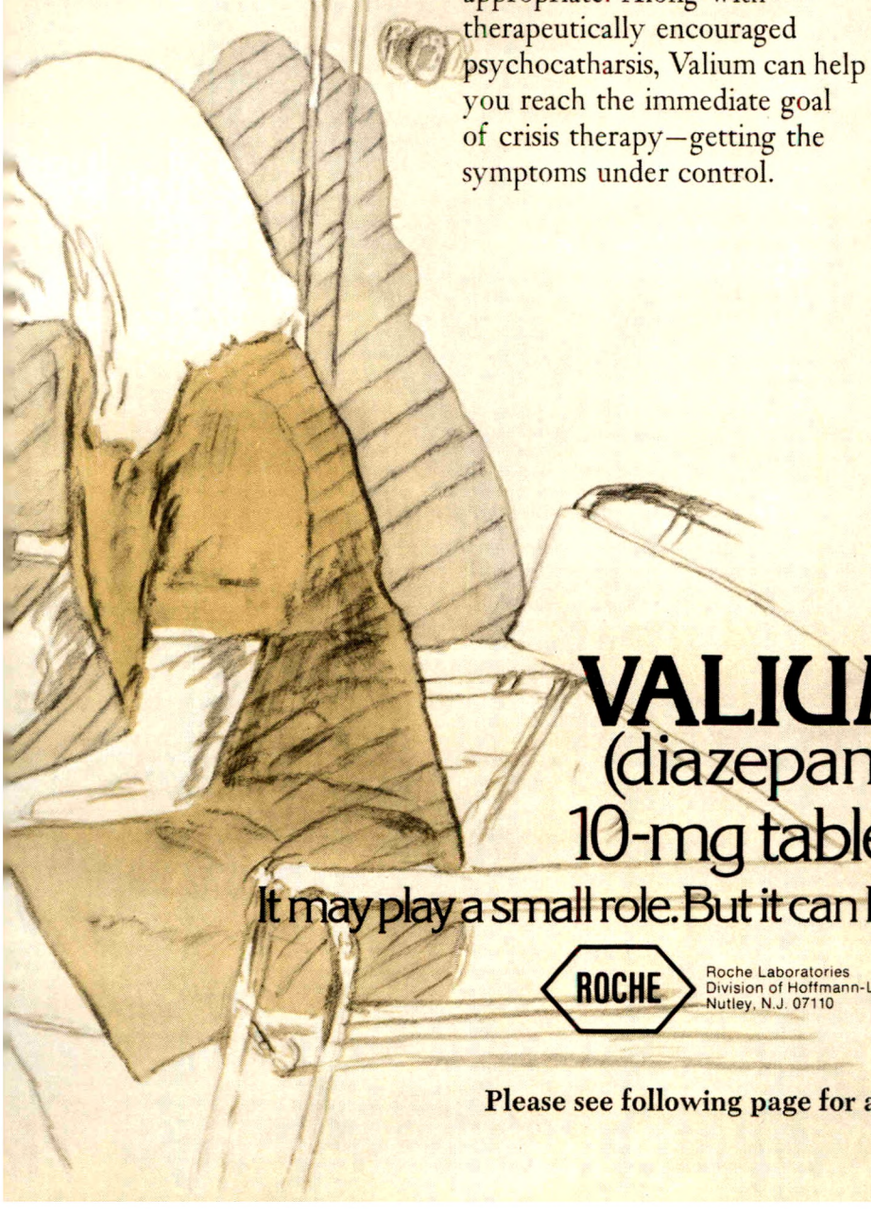


Covert conflicts may provoke an emotional state of emergency in the patient under long-term analysis. When the patient feels overwhelmed and threatened by his inability to resolve the conflict at hand, psychic tension and anxiety are likely to become excessive. At this critical time, he needs the immediate emotional support of crisis therapy. Your human responsiveness and empathy provide the patient with the necessary framework within which he can stabilize his emotional equilibrium. The calming effect of Valium (diazepam) may be useful along with crisis therapy to help the patient gain a measure of control over the situation.

Of course, emotional crises in this patient may also be stimulated by an extremely stressful event such as bereavement, divorce, financial disaster or natural catastrophe. Crisis therapy offers immediate measures when individuals cannot manage their reaction to powerful emotional stress. When psychic tension and anxiety are excessive, the adjunctive use of Valium (diazepam) may also be appropriate. Along with therapeutically encouraged psychocatharsis, Valium can help you reach the immediate goal of crisis therapy—getting the symptoms under control.

Although the role of Valium (diazepam) may be small in helping the individual in crisis, it can be significant. Valium 10 mg *t.i.d.* can provide prompt, effective action to reduce intense psychic tension and anxiety resulting from overreaction to severe stress. When the symptomatology has been sufficiently modified, Valium may be discontinued or the dosage adjusted with the 2-mg or 5-mg tablets *t.i.d.* or *q.i.d.*

Valium is generally well tolerated in the usual dosage range. The most frequently reported side effects have been drowsiness, fatigue and ataxia. Patients should be cautioned against engaging in hazardous occupations or driving when using Valium.



VALIUM®
(diazepam)
10-mg tablets

It may play a small role. But it can be an important one.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Please see following page for a summary of product information.

VALIUM®
(diazepam)
10-mg tablets



In the context of crisis therapy, helps reduce intense anxiety and tension.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

mirror, mirror on the wall, can this hospitalized schizophrenic relate to herself at all?





If the answer is "yes,"

then she can be helped to relate to others with the adjunctive use of

Trilafon®

brand of
perphenazine, NF

TRILAFON®
brand of perphenazine, NF
Tablets
REPETABS® Tablets
Syrup Concentrate Injection

CONTRAINDICATIONS TRILAFON is contraindicated in drug-associated central nervous system depression (barbiturates, alcohol, narcotics, analgesics, antihistamines). Perphenazine is contraindicated in the presence of existing blood dyscrasias, bone marrow depression and pre-existing liver damage, and in patients who are hypersensitive to perphenazine.

TRILAFON Injection should not be given to patients in coma or severely depressed states.

WARNINGS Usage in pregnancy: Perphenazine should only be given to pregnant patients when, in the judgment of the physician, the potential benefits outweigh the possible risks.

Perphenazine can lower the convulsive threshold in susceptible individuals; it should be used with caution in patients with convulsive disorders. If the patient is being treated with an anticonvulsant agent, increased dosage of that agent may be required when perphenazine is used concomitantly.

Perphenazine should be used with caution in patients with psychic depression.

Perphenazine is not recommended for children under 12 years of age.

Perphenazine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or oper machinery.

PRECAUTIONS As with any potent medication, patients receiving perphen should be under medical supervision, particularly if they are receiving doses. Patients who have had any severe reaction to phenothiazines or to pramine should be treated cautiously, under close medical supervision.

Although the following adverse reactions have not been reported in pa treated with perphenazine, the possibility that they might occur with TRI should be considered; blood dyscrasias (pancytopenia, thrombocytopenic pu leukopenia, eosinophilia); liver damage (biliary stasis); narrowing of the fields; pigmentation of the retina, cornea, or lens; cerebral edema; polyph photophobia; hyperpyrexia.

If hypotension develops, levarterenol (norepinephrine) can be used, bu epinephrine, because epinephrine's action is blocked and partly reversed by phenazine. Severe, acute hypotension has occurred with the use of phen zines and is of particular concern in patients with mitral insufficien pheochromocytoma.

A significant rise in body temperature may indicate an idiosyncratic rea to perphenazine; treatment with perphenazine should be stopped if this oc

The antiemetic effect of perphenazine can obscure signs of toxicity d overdosage of other drugs, or mask the symptoms of disease (eg, brain tum intestinal obstruction).

Contact dermatitis has been reported with a perphenazine solution; there contact of hands or clothing by those handling perphenazine solutions s be avoided.

POTENTIATION Since phenothiazines can potentiate the central-nervous-sy depressant actions of opiates, antihistamines, barbiturates, and alcohol,

Tablets 2,4,8,16 mg. REPETABS® 8 mg.	for maintenance therapy with cooperative patients
Concentrate 16 mg./5 cc. 4 oz. bottle with calibrated dropper	for "cheeking," geriatric, confused or otherwise untrustworthy psychotic patients
Injection 5 mg./cc., 10 cc. multiple-dose vial, 1 cc. ampule	for emergency or initial treatment of agitated psychotics



Schering

A potent phenothiazine to help:

- maintain alertness level
- stabilize behavioral patterns
- relieve anxiety/agitation
- increase patient response to psychotherapy

Trilafon®

brand of

perphenazine, NF

a major tranquilizer for in-hospital control and take-home therapy

---

he usual dosage of these agents is required when they are administered nitantly with TRILAFON. Patients should be cautioned that their response ohol may be increased while they are being treated with TRILAFON.
nothiazines also potentiate the effects of atropine, heat, and phosphorus icides, and should be used with caution in persons exposed to these agents.

RSE REACTIONS *Extrapyramidal reactions:* dystonia including protru- discoloration, aching and rounding of the tongue; tonic spasm of the mas- ry muscles, tight feeling in the throat, slurred speech, dysphagia, oculogyric trismus, torticollis, retrocollis, muscle weakness, and aching and numb- of the limbs; akathisia; motor restlessness; dyskinesia, parkinsonism; eflexia; and ataxia. The incidence and severity of these reactions usually se with increased dosage, but have occurred in some patients receiving osage. Reduction in dosage or treatment with an antispasmodic agent will y control extrapyramidal reactions. In some instances, however, these ons may persist after discontinuation of treatment with perphenazine.
sistent tardive dyskinesia: As with all antipsychotic agents, tardive dys- a may appear in some patients on long-term therapy or may appear after therapy has been discontinued. The risk appears to be greater in elderly ts on high-dose therapy, especially females. The symptoms are persistent n some patients appear to be irreversible. The syndrome is characterized by nical involuntary movements of the tongue, face, mouth or jaw (eg, pro- n of tongue, puffing of cheeks, puckering of mouth, chewing movements). times these may be accompanied by involuntary movements of extremities. is no known effective treatment for tardive dyskinesia; antiparkinsonism s usually do not alleviate the symptoms of this syndrome. It is suggested ll antipsychotic agents be discontinued if these symptoms appear. Should necessary to reinstitute treatment, or increase the dosage of the agent, or n to a different antipsychotic agent, the syndrome may be masked. It has reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Allergic reactions: erythema, pruritus, urticaria, eczema, anaphylactoid reactions, and local and generalized edema. In extremely rare instances, individual idiosyncrasy or hypersensitivity to phenothiazines has resulted in cerebral edema, circulatory collapse, and death. Photosensitization, asthma, and exfoliative dermatitis have also occurred in patients treated with phenothiazines.

Autonomic reactions: blurred vision, dry mouth or salivation, nasal congestion, nausea, vomiting, hypertension, tachycardia, hypotension, anorexia, urinary frequency or incontinence, and constipation. Significant autonomic effects have been infrequent in patients receiving less than 24 mg. perphenazine daily.

Other reactions: endocrine disturbances (lactation, gynecomastia, galactorrhea, disturbances in the menstrual cycle), headaches, mild insomnia, altered cerebrospinal fluid proteins, ECG abnormalities, reactivation of psychosis, paradoxical excitement, paranoid-like reactions, catatonia, and systemic lupus erythematosus-like syndrome. Hypnotic effects appear to be minimal, particularly in patients who are permitted to remain active. The following adverse reactions, though rare, have also been reported to be associated with perphenazine treatment: agranulocytosis; jaundice; hyperpigmentation of the skin; grand mal convulsions; failure of ejaculation; hyperglycemia.

Side effects with intramuscular TRILAFON Injection have been infrequent and transient. Dizziness or significant hypotension after treatment with TRILAFON Injection is a rare occurrence.

NOVEMBER 1972

Schering

Schering Corporation, Bloomfield, N.J. 07003

SWW-270

patients most in need of phenothiazines are often least able to cope with their side effects



TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)
added to the regimen helps alleviate phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia or hypotension and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines; in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Benztropine Mesylate, MSD) If they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000. Injection, containing 1.0 mg benztropine mesylate and 9.0 mg sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP DOHME

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Extrapyramidal symptoms that develop slowly usually are less responsive. They may require more prolonged treatment with 2 to 6 mg a day.

For more detailed information, see full prescribing information.

For the psychiatrist

The documented properties of DALMANE® (flurazepam HCl) for sleep

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

The properties of Dalmane have been carefully defined and thoroughly evaluated. Results of these investigations—many of which are cited here—have documented the effectiveness and relative safety of Dalmane when the etiology of insomnia indicates need for sleep medication.

Prompt sleep induction, effective through the night[1-13]

Consistently effective night after night[2,3,5,6,8-13]

Relative safety[11,14,15*]

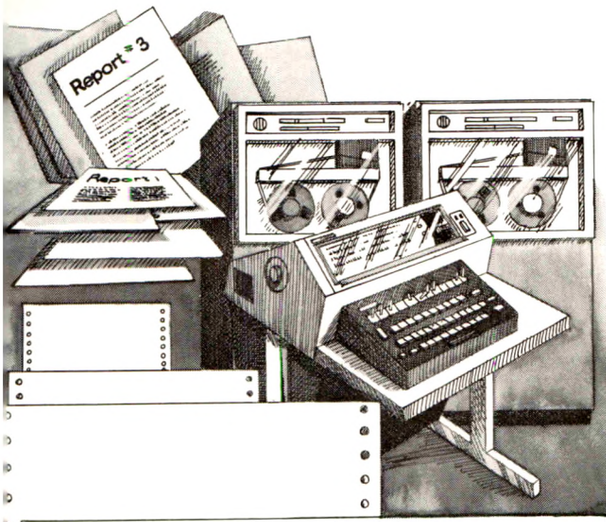
Usefulness in chronically anticoagulated patients[11]

1. Kales, A.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Philadelphia, Lippincott, 1969, p. 331. **2.** Kales, J., *et al.: Clin. Pharmacol. Ther., 12*:691, 1971. **3.** Jacobson, A., *et al.: Psychophysiology, 7*:345, 1970. **4.** Kales, A., and Kales, J.: *J.A.M.A., 213*:2229, 1970. **5.** Frost, J. D., Jr.: "A Syster for Automatically Analyzing Sleep," Scientific Exhibit pre sented at Clinical Convention, A.M.A., Boston, Nov. 2 Dec. 2, 1970; and at 42nd Annual Scientific Meetin Aerospace Med. Assoc., Houston, April 26-29, 197 **6.** Karacan, I., *et al.:* "The Sleep Laboratory in the Invest gation of Sleep and Sleep Disturbances," Scientifi Exhibit presented at Amer. Psychiat. Assoc., Washingtor D.C., May 3-7, 1971. **7.** Hartmann, E.: *Psychopharma cologia (Berl.), 12*:346, 1968. **8.** Dement, W. C.: Data o file, Medical Department, Hoffmann-La Roche Inc Nutley, N.J. **9.** Vogel, G. W.: Data on file, Medical Depar ment, Hoffmann-La Roche Inc., Nutley, N.J. **10.** Kales, A and Kales, J. D.: *Pharmacol. Physicians, 4*:1, 197 **11.** Data on file, Medical Department, Hoffmann-La Roch Inc., Nutley, N.J. **12.** Kales, A., *et al.: Arch. Gen. Psychia 23*:226, 1970. **13.** Meyer, J. A.: "Flurazepam Hydrochlo ide for the Short-Term Treatment of Insomnia in th

*Generally, when adverse effects were reported clinically with Dalmane (flurazepam HCl), they were mild and infrequent. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most often, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

Little "hang-over" effect on awakening[11,14]

Hospitalized Post-Surgical Patient," Scientific Exhibit presented at AAGP, San Francisco, Calif., Sept. 28-Oct. 1, 1970. **14.** Zimmerman, A. M.: *Curr. Ther. Res., 13*:18, 1971. **15.** Greenblatt, D., and Shader, R.: *Ann. Intern. Med., 77*:91, 1972.



Data about Dalmane (flurazepam HCl) on request

The references cited constitute only a part of the Dalmane bibliography. Additional data are available through the Roche Professional Services Department. Augmenting this service is RETRIEVE, a computer-operated data retrieval system which screens data from the published English language papers on Dalmane to help provide rapid answers to your specific questions. Coded into the computerized index are parameters that include patient age, sex, condition; product dose, side effect, frequency of administration; other medications or therapy; length, type and size of study, and pharmacology.

For specific answers to any questions you might have about Dalmane, write or call: Roche Professional Services Department, Roche Laboratories, Nutley, N.J. 07110. Telephone: (201) 235-2355.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Drug-Induced Constipation

Many of the widely prescribed drug categories—antacids, analgesics, barbiturates, tranquilizers, diuretics, hematinics, antihistamines, anticholinergics, antispasmodics, narcotics, muscle relaxants, antihypertensives, antidepressants—may interfere with the regular bowel action.

The value of SENOKOT Tablets/Granules has been clearly demonstrated in drug-induced or drug-aggravated constipation. In 5 studies* SENOKOT therapy was effective in 98.5% of 613 cases.

When an essential drug you prescribe induces or aggravates constipation, Rx or recommend a SENOKOT laxative product. Compatible with antacids, clinically tested, shown not to interfere with the action of numerous drugs, it is the *natural* choice to keep things moving gently, comfortably, effectively.

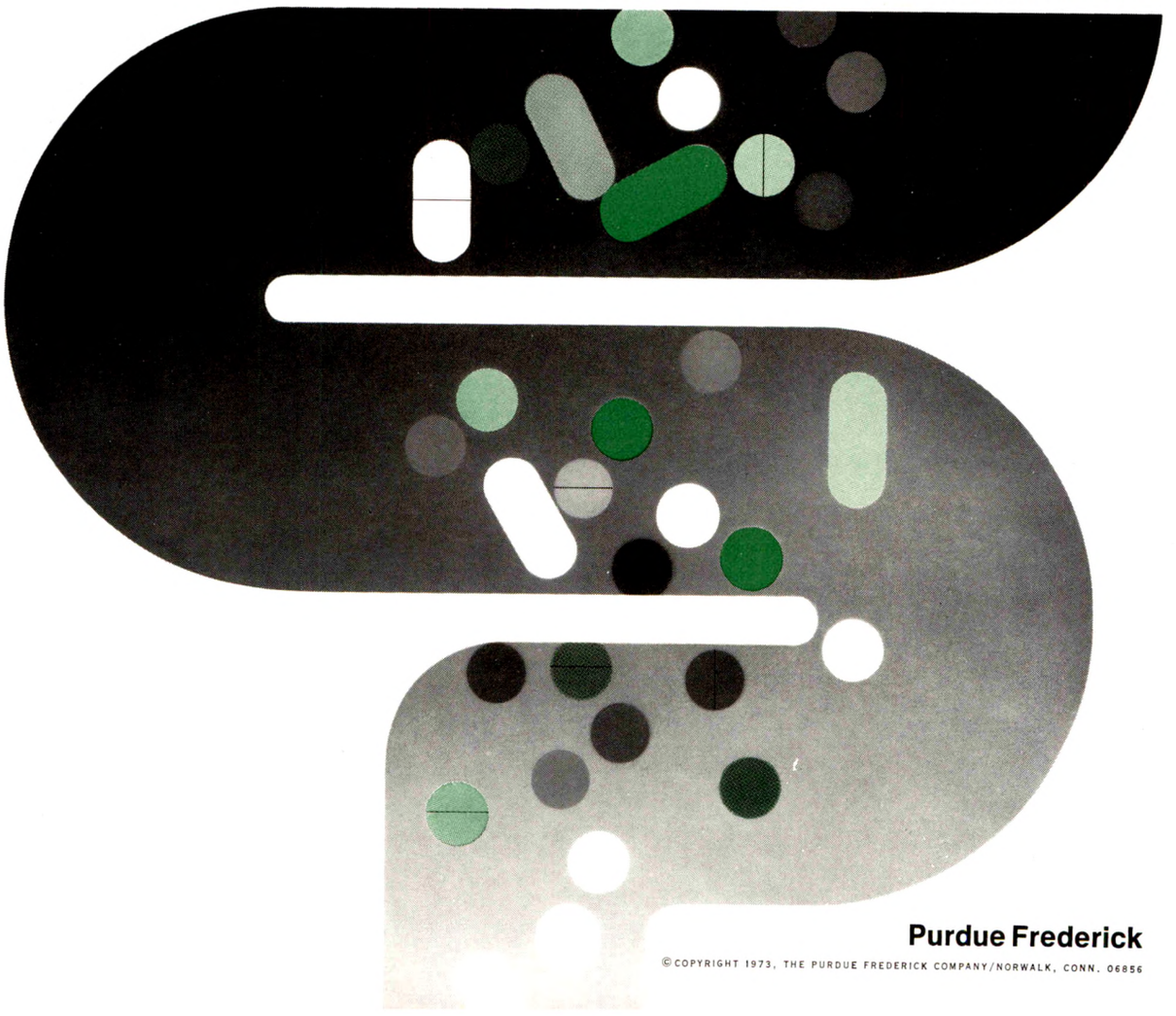
Supplied: SENOKOT Tablets (small, easy-to-swallow)—Bottles of 50 and 100. SENOKOT Granules (delicious, cocoa-flavored)—4, 8 and 16 ounce (1 lb.) canisters.

*References on request.

Counteract with Senokot

(standardized senna concentrate)
Tablets/Granules

a natural laxative



Purdue Frederick

©COPYRIGHT 1973, THE PURDUE FREDERICK COMPANY/NORWALK, CONN. 06856

We've got a new name



A (potassium gluconate-potassium chloride)

(but that's all).

KALYUM™ Liquid (potassium gluconate-potassium chloride), that's our old name. The name you knew us by.

We liked it. After all it's the Latin pronunciation for "potassium." And potassium supplementation is what we're all about.

So why change our name to KOLYUM™ Liquid (potassium gluconate-potassium chloride)?

It just happens that our old name could possibly be mistaken for the name of a large product in another therapeutic category. So we decided to eliminate any chance of confusion by changing *our* name.

But our name is all we changed. Kolyum (new name) is still the same good-tasting cherry flavored potassium supplement you trusted under the name of Kalyum.

So from now on—whenever you want effective potassium supplementation *without sodium and calories*, remember our new name: Kolyum Liquid.

Kolyum Liquid.

Potassium supplementation gets a neat new name.

PRESCRIBING INFORMATION

DESCRIPTION—Each 15 ml tablespoon provides 20 mEq of potassium ion and 3.34 mEq of chloride ion in a sugar free, cherry flavored vehicle.

INDICATION—Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS—Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

PRECAUTIONS—Potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease. Extreme caution should be used in patients receiving aldosterone antagonists or potassium sparing diuretics. In both cases potassium intoxication might occur.

ADVERSE REACTIONS—Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment and tall peaked T waves. DOSAGE—The usual adult dosage is one tablespoonful (15 ml) in one fluid ounce or more of water twice daily. This supplies 40 mEq of potassium ion which is the approximate minimal adult daily requirement, as well as 6.68 mEq of chloride ion. Deviations from this recommendation may be indicated, since no average total daily dose can be defined but must be governed by close observation for clinical effects. OVERDOSAGE—Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours. SUPPLIED: Pints and gallons. Dispense in amber glass containers.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623





When the symptoms add up to depression

ADAPIN®
(Doxepin HCl)

opens the patient to your counsel

Biphasic action helps you "get to" the depressed patient quickly.

Depressed patients are often difficult to reach. Some are lethargic: withdrawn. And in others, agitation masks the underlying depression.

Adapin (doxepin HCl) works on either—or both—phases: depression/agitation-depression. That's how Adapin quickly opens the patient to your counsel. Lets you work with him as the drug works to lift his depressive symptoms (usually in two to three weeks).

Dosage flexibility allows you to choose therapeutic approach.

In situations where drowsiness is clinically undesirable, you can start the patient on 10 mg. Adapin t.i.d. for four days (without reduced therapeutic effect) titrating the dosage upward after that as indicated. In patients where you deem drowsiness to be a desirable effect, you can initiate therapy with 25 mg. or more t.i.d. as the clinical situation dictates.

Further, with Adapin, you can titrate dosage upward in 10 mg. increments, allowing you greater therapeutic flexibility.

Single entity; low possibility of "cross reactions."

Adapin is single entity therapy. And there have been few reported instances of drug "cross reactions." In fact, one investigator[1] reported no adverse interactions between doxepin HCl [Adapin] and alcohol, hypnotics, neuroleptics, antihypertensive drugs, oral hypoglycemic agents, or anticonvulsants.

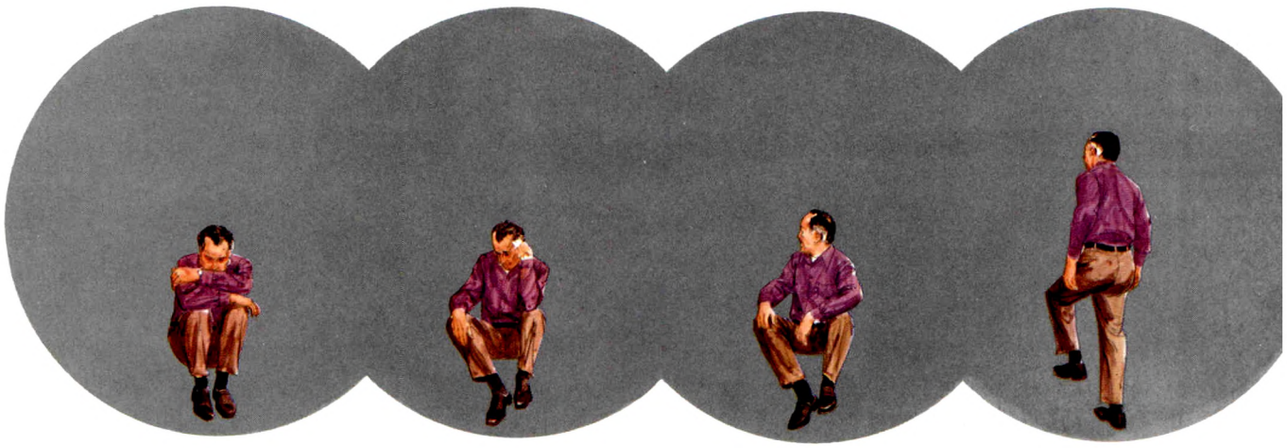
No addictive potential. No reported withdrawal symptoms.

Well tolerated by patients (even the elderly) with concomitant organic disease.

Low starting dosage; fine dosage titration.

1. Ayd, Frank J. Jr.: Long Term Administration of Doxepin Dis Nerv Syst 32:617-22, Sept., 1971

Please see following page for prescribing information

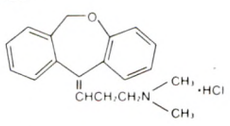


When the symptoms add up to depressio

ADAPIN®
(Doxepin HCl)

opens the patient to your counsel

COMPOSITION: Each Adapin capsule contains 10 mg., 25 mg., or 50 mg. of doxepin as the hydrochloride.



INDICATIONS: Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

CONTRAINDICATIONS: Adapin is contraindicated in patients with glaucoma or a tendency toward urinary retention, and in patients with demonstrated hypersensitivity to Adapin.

WARNINGS:

1. MAO inhibitors should be discontinued at least two weeks prior to cautious initiation of therapy with Adapin.
2. Adapin has not been evaluated in pregnant patients and should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.
3. Usage of Adapin in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Patients should be warned of the possible occurrence of drowsiness and cautioned against driving a motor vehicle or operating hazardous machinery. The effects of alcoholic beverages may be increased. Since suicide is an inherent risk in depressed patients, they should be closely supervised. The possibility of activating or unmasking latent psychotic symptoms during therapy should be kept in mind. Significant blocking of the antihypertensive effect of guanethidine is exerted at dosages of 300 mg. per day or higher. Potentiation of norepinephrine response in animals has been noted, but this effect has not been observed in humans.

ADVERSE REACTIONS: Anticholinergic Effects—Dry mouth, blurred vision and constipation; CNS Effects—Drowsiness; Cardiovascular Effects—Tachycardia and hypotension. Infrequently: extrapyramidal symptoms, gastrointestinal reactions, secretory effects (increased sweating), weakness, dizziness, fatigue, weight gains, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE: 10 mg. to 25 mg. t.i.d. to start. An initial dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients. Usual optimum dosage is 75 to 150 mg. per day. In some patients with mild emotional symptomatology, including that which may accompany organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control. More severe anxiety and/or depression may require 50 mg. t.i.d. to start, gradually increased to 300 mg. per day.

OVERDOSAGE: Symptoms include an increase of the reported adverse reactions, primarily excessive sedation and anticholinergic effects as blurred vision and dry mouth. Other effects may be pronounced tachycardia, hypotension and extrapyramidal symptoms. Treatment is essentially symptomatic with supportive therapy in the case of hypotension and excessive sedation.

SUPPLIED: Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 18-356-71) and 25 mg. (NDC 18-357-71) capsules in bottles of 100 and 50 mg. (NDC 18-358-65) capsules in bottles of 50. Caution: Federal law prohibits dispensing without a prescription.

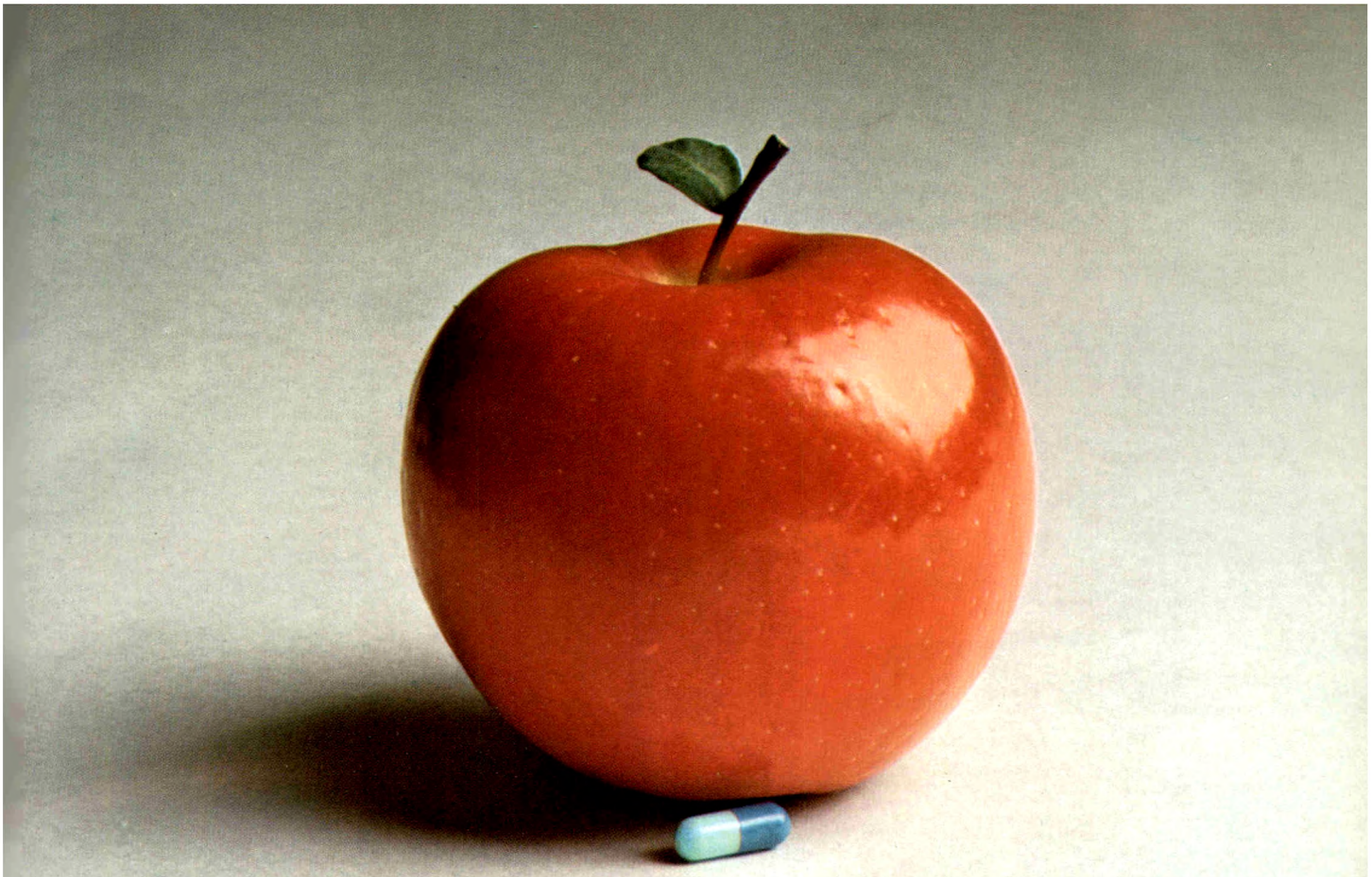
PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623

6749

Printed in U.S.A.

7/



Once-a-day maintenance therapy. Introducing New Navane® 20 mg. (thiothixene) capsules

Once-a-day maintenance...

Once you've controlled acute psychosis or psychotic depression with a t.i.d. regimen, some patients can be maintained on one new Navane 20 mg. capsule a day. And for patients requiring higher dosages, two or three capsules, once a day, may be sufficient. This once-a-day regimen can reduce the risk of missed doses, with no loss of efficacy.

Once-a-day efficacy...

A recent double-blind, crossover study[1] compared Navane capsules, t.i.d., with an equivalent-dose once-a-day regimen. Both groups had statistically equivalent, significant clinical improvement over baseline at the end of the study period. And although the difference in extrapyramidal side effects was not statistically significant, the once-a-day group had a lower score.

Once-a-day economy...

For inpatient therapy, once-a-day Navane capsules can provide a saving of valuable nursing time. And for both institutions and outpatients, the 20-mg. capsule has another economy advantage: it's less costly than two 10-mg. or four 5-mg. capsules.

Navane 20-mg. It's a new dosage strength to maintain control of psychotic behavior. Effectively. Conveniently. And economically.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

1. Data on file, Roerig.

For prescribing information, including adverse reactions and contraindications, please see following page of this advertisement.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg., 2 mg., 5 mg., 10 mg., 20 mg.
Concentrate: 5 mg./cc.
Intramuscular: 2 mg./cc.

PRESCRIBING INFORMATION
Navane® (thiothixene)
Capsules 1 mg., 2 mg., 5 mg., 10 mg., 20 mg.
(thiothixene hydrochloride)
Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane (thiothixene), there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg./kg./day), rabbits (3 to 50 mg./kg./day), and monkeys (1 to 3 mg./kg./day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in children–The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane (thiothixene) may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane [thiothixene] for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis), have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration – As with all intramuscular preparations, Navane (thiothixene hydrochloride) Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower- and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following reactions have been reported with Navane. However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane (thiothixene) is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur, although it usually subsides with continuation of Navane therapy. The incidence of sedation appears to be similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudoparkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: Although not reported with Navane, certain antipsychotic agents have been associated with persistent dyskinesias. Tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leucocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration because safe conditions for its use have not been established.

Dosage and Administration. Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level based on patient response.

Usage in children under 12 years of age is not recommended.

Navane Intramuscular Solution–For Intramuscular Use Only. Where more rapid control and treatment of behavior is desirable, the intramuscular form of Navane (thiothixene hydrochloride) may be indicated. It is also of benefit where the very nature of the patient's symptomatology whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg. of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg./day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane Capsules and Concentrate appear in the following paragraphs.

Navane Capsules; Navane Concentrate–In milder conditions, an initial dose of 2 mg. three times daily. If indicated, a subsequent increase to 15 mg./day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg. twice daily.

The usual optimal dose is 20 to 30 mg. daily. If indicated, an increase to 60 mg./day total daily dose is often effective. Exceeding a total daily dose of 60 mg. rarely increases the beneficial response.

Some patients have been successfully maintained on once-a-day Navane (thiothixene) therapy.

Overdosage. Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, disturbances of gait, or coma.

Treatment: Essentially symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and intramuscular keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of blood pressure.

If CNS depression is present, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Picrotoxin or pentylenetetrazol should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

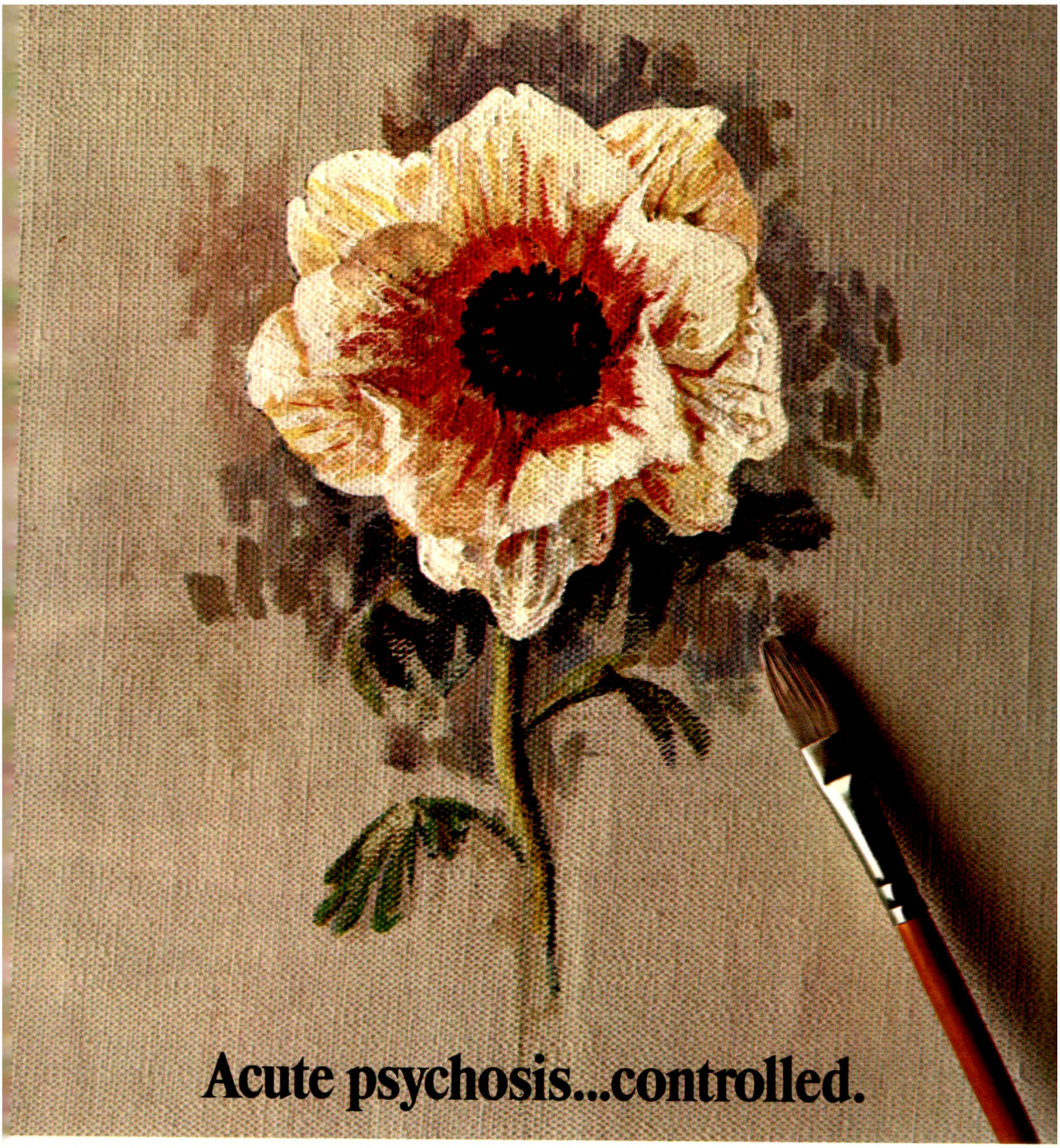
There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is available as capsules containing 1 mg., 2 mg., 5 mg., and 10 mg. in bottles of 100 and 1,000. Navane is also available as capsules containing 20 mg. of thiothixene, in bottles of 100 and 500.

Navane (thiothixene hydrochloride) Concentrate is available in 120 cc. (4 oz.) bottles with an accompanying dropper calibrated at 2 mg., 3 mg., 5 mg., 6 mg., 8 mg. and 10 mg. Each cc contains thiothixene hydrochloride equivalent to 5 mg. of thiothixene. Contains alcohol, U.S.P. 7.0% v/v. (small loss unavoidable).

Navane (thiothixene hydrochloride) Intramuscular Solution is available in a 2 cc. amber glass vial in packages of 10. Each cc. contains thiothixene hydrochloride equivalent to 2 mg. of thiothixene, dextrose 5% w/v, benzyl alcohol 0.9% w/v

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



Navane (thiothixene) helps reduce the intensity and frequency of acute psychotic symptoms. With Navane, confusion, disorientation and other manifestations of acute psychosis may be controlled. And, as acute symptomatology decreases, the patient may be better able to readjust to therapeutic, family and community relationships and responsibilities. Navane...an effective anti-psychotic for acute psychosis.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Navane®

(thiothixene) (thiothixene hydrochloride)

Capsules 1 mg., 2 mg., 5 mg., 10 mg. Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

to help control psychotic behavior

For prescribing information, including adverse reactions and contraindications, please see facing page of this advertisement.

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

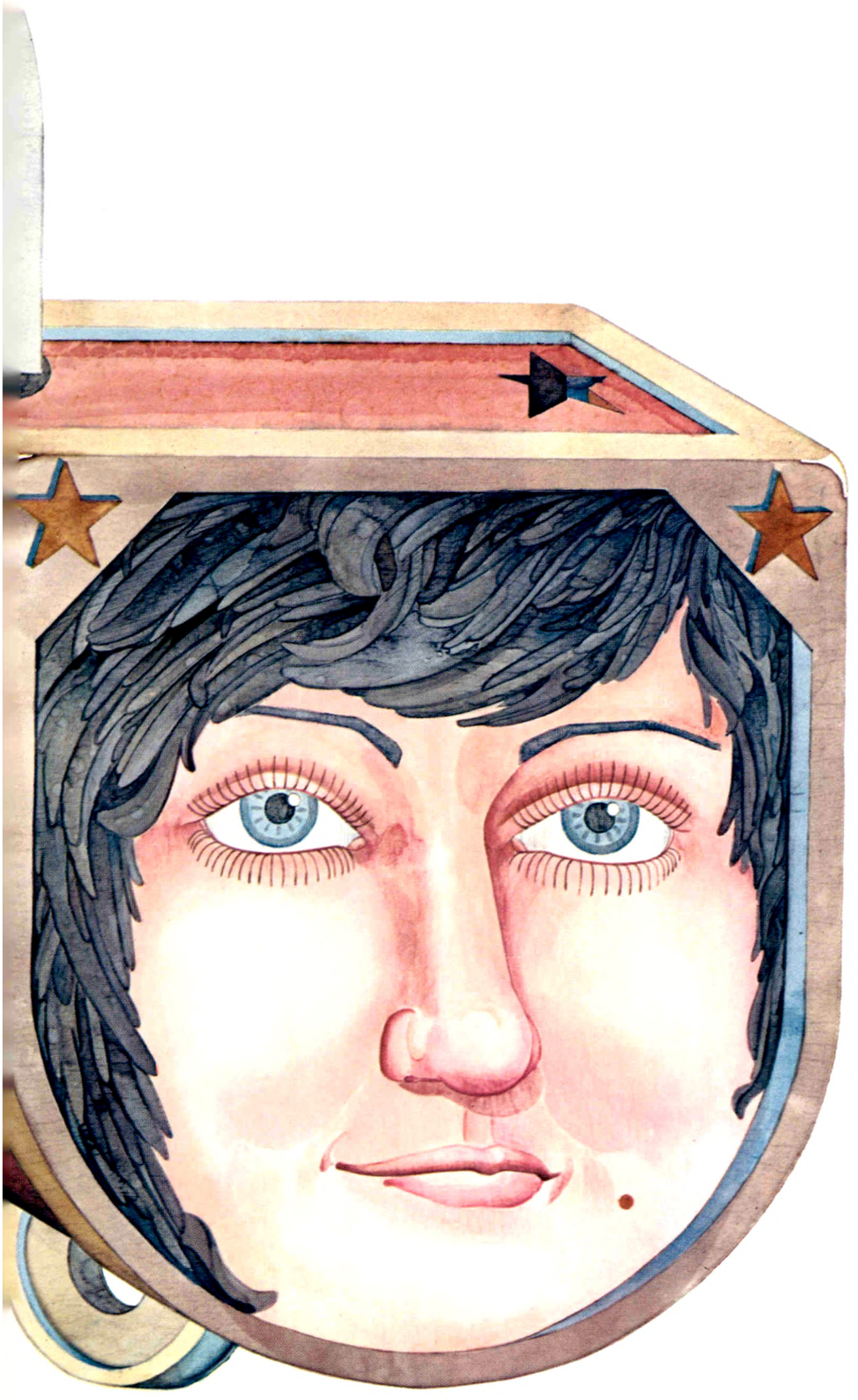
In severe anxiety

Serax®

(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

Please see important information on page after next.



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

The Country Place

LITCHFIELD, CONNECTICUT



THE COUNTRY PLACE is a residential community for the emotionally disturbed adult who has more insight than he can use, who knows how he should act but withdraws from action.

THE COUNTRY PLACE offers
a home where he is understood
a work place where he can cope with the demands
a community where he can find social identity

THE COUNTRY PLACE
provides team work in socially useful projects
self help through interaction in groups
exploration of existent reality

THE COUNTRY PLACE maintains a well-trained professional staff for individual and group therapy psychodrama, art, dance and music therapy, as well as sports and games

WEEK END WORKSHOPS for professionals interested in studying our method of helping the disturbed person in creating a new identity

Address inquiries to:

RENEE NELL, ED.D.
THE COUNTRY PLACE
Litchfield, Conn. 06759
Telephone: (203) 567-8763

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director

OSCAR ROZETT, M.D., Medical Administrator

GRANVILLE L. JONES, M.D., Director of Research

DONALD H. GENT, M.D., Chief, Adolescent Program

MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator

The American Journal of Psychiatry

The October 1973 issue will feature

A Special Section on

Women in Psychiatry and Medicine

and

Official APA Reports


R.S.V.P.

She just doesn't respond to hings. No interest. No energy. Discouraged.

It may be mild depression. he needs help...and she needs it ow.

Counsel and reassurance ay suffice. But if you decide pportive medication is indi- ated, Ritalin can offer prompt enefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
(methylphenidate) helps the patient respond in mild depression*

italin® hydrochloride ©
ıethylphenidate hydrochloride)

ABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

ONTRAINDICATIONS
arked anxiety, tension, and agitation, since talin may aggravate these symptoms. Also ontraindicated in patients known to be ypersensitive to the drug and in patients with aucoma.

ARNINGS
italin should not be used in children under x years, since safety and efficacy in this age roup have not been established.
ufficient data on safety and efficacy of long- rm use of Ritalin in children with minimal rain dysfunction are not yet available.
though a causal relationship has not been stablished, suppression of growth (*ie*, weight ain and/or height) has been reported with ng-term use of stimulants in children. herefore, children requiring long-term ierapy should be carefully monitored.
italin should not be used for severe depres- on of either exogenous or endogenous origin for the prevention of normal fatigue states.
italin may lower the convulsive threshold in atients with or without prior seizures; with or ithout prior EEG abnormalities, even in osence of seizures. Safe concomitant use of nticonvulsants and Ritalin has not been stablished. If seizures occur, Ritalin should e discontinued.
se cautiously in patients with hypertension. lood pressure should be monitored at appro- riate intervals in all patients taking Ritalin, specially those with hypertension.
rug Interactions
italin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported.
Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4753-1 17

This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

CIBA

When anxiety* brings her to your office again...and again...and again

Stelazine®

brand of

trifluoperazine HCl 2 mg. tablets

Helps the chronic anxiety patient* to function more normally

The patient with chronic neurotic anxiety is among the most demanding you are called upon to treat.

Her composure is threatened almost daily by her habitual overreaction to stressful circumstances whether real or imagined—reactions which reassurance and counseling may not fully ease.

When anxiety levels reach a point where they disrupt the patient's ability to function, in addition to your counseling supportive medication may be required.

In such cases, 'Stelazine' can provide incisive control of anxiety with a minimum of excessive sedation. The recommended b.i.d. dosage is convenient and economical. And dependence and withdrawal symptoms have not been reported with 'Stelazine' therapy.

*'Stelazine' has been evaluated as possibly effective for this indication. See Brief Summary.

Before prescribing, see complete prescribing information, including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

Indications
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of the manifestations of psychotic disorders.

Possibly effective: To control excessive anxiety, tension and agitation as seen in neuroses or associated with somatic conditions.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose or greatly depressed states due to C.N.S. depressants; blood dyscrasias; bone marrow depression; liver damage.

Warnings: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery), especially during the first few days' therapy.

Use in pregnancy only when necessary for patient's welfare.

Precautions: Use cautiously in angina. Avoid high doses and parenteral administration when cardiovascular system is impaired. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Additive effect is possible with other C.N.S. depressants. Prolonged administration of high doses may result in cumulative effects with severe C.N.S. or vasomotor symptoms. If retinal changes occur, discontinue drug. Agranulocytosis, thrombocytopenia, pancytopenia, anemia, cholestatic jaundice, liver damage have been reported.

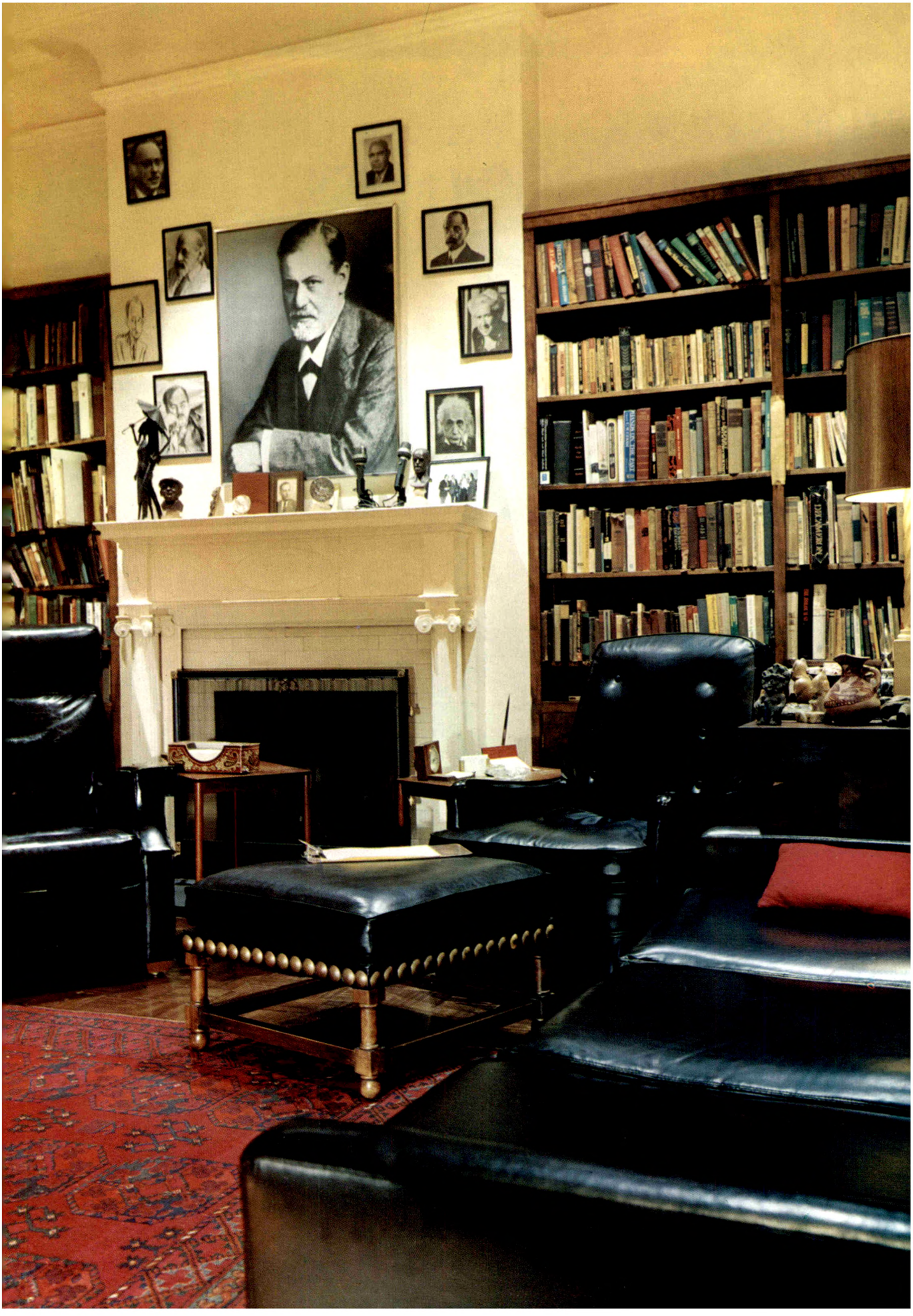
Adverse Reactions: Drowsiness, dizziness, skin reactions, rash, dry mouth, insomnia, amenorrhea, fatigue, muscular weakness, anorexia, lactation, blurred vision. Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudoparkinsonism, persistent tardive dyskinesia.

Other adverse reactions reported with Stelazine (trifluoperazine HCl, SK&F) or other phenothiazines: Some adverse effects are more frequent or intense in specific disorders (e.g., mitral insufficiency or pheochromocytoma).

Grand mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat, and organophosphorus insecticides; nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, inhibition of ejaculation; reactivation of psychotic processes, catatonic-like states; hypotension (sometimes fatal); cardiac arrest; leukopenia, eosinophilia, pancytopenia, agranulocytosis, thrombocytopenic purpura; jaundice, biliary stasis; menstrual irregularities, galactorrhea, gynecomastia, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits. EKG changes have been reported, but relationship to myocardial damage is not confirmed. Discontinue long-term, high-dose therapy gradually. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 1 mg., 2 mg., 5 mg. and 10 mg., in bottles of 100; Injection, 2 mg./ml.; and Concentrate, 10 mg./ml.

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630, under Stelazine® trademark license from SmithKline Corporation, Philadelphia, Pa.



recovery room

The psychiatric setting... and the role of TRIAVIL®.

Change, growth, and insight can flourish in this private and protected place, for seldom is the doctor-patient relationship more meaningful than in this psychotherapeutic setting. There are situations and stages, however, when time and talk are not enough... when the careful use of a psychotropic agent such as TRIAVIL can help accelerate recovery. Specifically, when TRIAVIL is part of the treatment program, you may anticipate these important therapeutic benefits:

The TRIAVIL Potential

1. By relieving moderate to severe anxiety or agitation with depression, the patient may become more accessible and cooperative.
2. As somatic manifestations of anxiety and depression are controlled, attention may be focused on the underlying factors of the condition.
3. While the psychotherapeutic process proceeds, symptomatic relief may enable the patient to function more effectively in his daily activities.

In addition, since TRIAVIL combines a tranquilizer with an antidepressant, confused and troubled patients need remember to take only one type of tablet, rather than two. And patients are offered economical therapy compared to a tranquilizer and an antidepressant prescribed separately.

Treatment with TRIAVIL a balanced view.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential, particularly until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

a tranquilizer – antidepressant

Triavil®

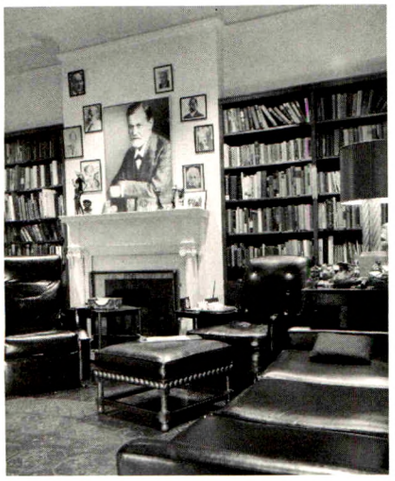
a potential aid in the psychotherapeutic process when patients exhibit moderate to marked anxiety or agitation with depression

containing perphenazine and amitriptyline HCl

MSD MERCK SHARP & DOHME

For additional prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety
or agitation with depression



Triavil® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practice when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.
A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.
If hypotension develops, epinephrine should not be employed as its action is blocked and partially reversed by perphenazine.
Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.
Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.
Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential.
Discontinue several days before elective surgery if possible.
Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyper-reflexia, dystonia, akathisia, dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and EKG abnormalities (quinidine-like effect); reactivation of psychotic

processes; catatonic-like states; autonomic reactions, such as dryness of the mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitivity; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastic distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance—vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

Anxiety Amelioration—in terms of motor, affective, autonomic and verbal phenomenon.

1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.



First day in the hospital and all efforts will be directed toward returning her to the community.

For psychotic patients with mixed anxiety-depression, Mellaril has been found useful to help patients participate more fully in the entire therapeutic program. Continued medication with Mellaril is often basic to helping patients prepare for and participate in outpatient treatment programs that bridge the gap between hospital and community.

With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

MELLARIL®
(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic patients with mixed anxiety-depression

A36

Before prescribing or administering, see Sandoz literature for full produ information. The following is a brief summary.

Contraindications: Severe central nervous system depressio comatose states from any cause, hypertensive or hypotensive hea disease of extreme degree.

Warnings: Administer cautiously to patients who have previous exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jau dice) to phenothiazines. Phenothiazines are capable of potentiatir central nervous system depressants (e.g., anesthetics, opiates, a cohol, etc.) as well as atropine and phosphorus insecticides. Du ing pregnancy, administer only when the potential benefits excee the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopen and/or agranulocytosis and convulsive seizures. In epileptic p tients, anticonvulsant medication should also be maintained. Pi mentary retinopathy may be avoided by remaining within the re ommended limits of dosage. Administer cautiously to patients pa ticipating in activities requiring complete mental alertness (e.g driving), and increase dosage gradually. Orthostatic hypotensic is more common in females than in males. Do not use epinephrir in treating drug-induced hypotension since phenothiazines may i duce a reversed epinephrine effect on occasion. Daily doses excess of 300 mg. should be used only in severe neuropsychiatr conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especial with large doses, early in treatment; infrequently, pseudoparki sonism and other extrapyramidal symptoms; nocturnal confusio hyperactivity, lethargy, psychotic reactions, restlessness, and hea ache. *Autonomic Nervous System*—Dryness of mouth, blurred v sion, constipation, nausea, vomiting, diarrhea, nasal stuffines and pallor. *Endocrine System*—Galactorrhea, breast engorgemer amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin* Dermatitis and skin eruptions of the urticarial type, photosens tivity. *Cardiovascular System*—ECG changes (see *Cardiovascular E fects* below). *Other*—A single case described as parotid swelling. The following reactions have occurred with phenothiazines ar should be considered: *Autonomic Reactions*—Miosis, obstipatio anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoli tive dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranuloc tosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplast anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edem angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, bilia stasis. *Cardiovascular Effects*—Changes in terminal portion of ele trocardiogram, including prolongation of Q-T interval, lowerir and inversion of T-wave, and appearance of a wave tentative identified as a bifid T or a U wave have been observed with phen thiazines, including Mellaril (thioridazine); these appear to be r versible and due to altered repolarization, not myocardial damag While there is no evidence of a causal relationship between thes changes and significant disturbance of cardiac rhythm, sever sudden and unexpected deaths apparently due to cardiac arre have occurred in patients showing characteristic electrocardi graphic changes while taking the drug. While proposed, period electrocardiograms are not regarded as predictive. Hypotensio rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akath sia, agitation, motor restlessness, dystonic reactions, trismu torticollis, opisthotonus, oculogyric crises, tremor, muscular rigi ity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent ar sometimes irreversible tardive dyskinesia, characterized by rhyt mical involuntary movements of the tongue, face, mouth, or ja (e.g., protrusion of tongue, puffing of cheeks, puckering of mout chewing movements) and sometimes of extremities may occur c long-term therapy or after discontinuation of therapy, the risk b ing greater in elderly patients on high-dose therapy, especial females; if symptoms appear, discontinue all antipsychotic agent Syndrome may be masked if treatment is reinstituted, dosage increased, or antipsychotic agent is switched. Fine vermicula movements of tongue may be an early sign, and syndrome ma not develop if medication is stopped at that time. *Endocrine Di turbances*—Menstrual irregularities, altered libido, gynecomasti lactation, weight gain, edema, false positive pregnancy test *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperp rexia; behavioral effects suggestive of a paradoxical reaction, i cluding excitement, bizarre dreams, aggravation of psychoses, ar toxic confusional states; following long-term treatment, a peculia skin-eye syndrome marked by progressive pigmentation of sk or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

73-824 SANDO

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERSEY 0793

THE AMERICAN JOURNAL OF PSYCHIATRY

An Overview of Crisis Intervention in the Emergency Rooms of General Hospitals

BY GIAMPIERO BARTOLUCCI, M.D., AND CALVIN S. DRAYER, M.D.

General hospitals throughout the land have—and in all likelihood will continue to have—emergency rooms that are more or less adequate. It seems strategically sound to do all we can to strengthen these sites of centralized help for the wide variety of medicosocial predicaments that can be expected to recur in all communities. In this paper the authors summarize some historical and theoretical considerations they believe can contribute to a productive refinement of existing emergency services at a time when direct federal support for health services is being drastically curtailed.

IN JANUARY 1751, BENJAMIN FRANKLIN wrote a petition for "sundry inhabitants" of Pennsylvania to the House of Representatives of that province. He began this petition by pointing out:

> THAT with the Numbers of People, the number of Lunaticks or Persons distempered in Mind and deprived of their rational Faculties, hath greatly encreased in this Province.
>
> That some of them going at Large are a Terror to their Neighbors, who are daily apprehensive of the Violences they may commit; and others are continually wasting their Substance, to the great Injury of themselves and Families, ill disposed Persons wickedly taking Advantage of their unhappy Condition, and drawing them into unreasonable Bargains, &c.
>
> That few or none of them are so sensible of their Condition, as to submit voluntarily to the Treatment their respective Cases require, and therefore continue in the same deplorable State during their Lives; whereas it has been found by the Experience of many Years, that above two Thirds of the Mad People received into Bethlehem Hospital, and there treated properly, have been perfectly cured (1).

This paper was written at the invitation of the Editor.

The authors are with the Pennsylvania Hospital, Eighth and Spruce Sts., Philadelphia, Pa. 19107, where Dr. Bartolucci is Clinical Director of the Hall-Mercer Community Mental Health/Mental Retardation Center and Dr. Drayer is Consulting Psychiatrist.

The purpose of this petition was to promote the building of "a small Provincial Hospital." Nearly six years later the east wing of the Pennsylvania Hospital was ready to receive patients. In 1840, one-half of the buildings in this general hospital and two-thirds of the adjacent grounds were still being used for the care of psychiatric patients.

Today major efforts are being made through community mental health centers and mobilization of related facilities to help "Persons distempered in Mind and deprived of their rational Faculties" to resolve their problems without being actually hospitalized. But trust in the sometimes maligned medical model persists in "sundry persons" in most communities, as reflected in their increasingly ready resort to the emergency rooms of their local general hospitals.

Motivations of the public to use emergency room facilities have not been clearly reported; they must be deduced from some of the phenomena that have been identified in studies of emergency room service utilization. The fact that even those who have a personal physician tend to bypass this professional's services and go directly to the local emergency room (2–5), and the fact that about half of the cases seen in emergency rooms since 1945 have not been considered to be true emergencies (6), make it reasonable to speculate that the average patient is seeking an immediately available, secure environment such as a hospital for the treatment of his ills and problems. There seems to be a growing lack of trust in the readiness and ability of the private sector of health care, embodied by general practitioners, to deliver these services quickly and to the patient's satisfaction. In the opinion of much of the public, the emergency room and its staff have apparently become the primary deliverers of health and social services.

It can be seen therefore that modern emergency rooms are a fertile field for the active application of the principles of community mental health. Furthermore, emergency rooms in areas currently served by community mental health centers may well be facing an increase in demands for help from people whose problems are pre-

dominantly emotional. It is now quite clear that community mental health centers no longer enjoy the favor of the current government funding agencies. Their existing services may have to be curtailed, if not eliminated completely. Obviously people will continue to encounter predicaments (so-called "crises"[1]); therefore, it is particularly pertinent at the present time to review pragmatically the theory and practice of predicament (crisis) intervention insofar as such intervention relates to emergency room functions.

GENERAL THEORETICAL CONSIDERATIONS

A useful approach to this review of early intervention is by means of the concepts of primary, secondary, and tertiary prevention of emotional disabilities. Caplan (8) has succinctly defined these grades of prevention. They are programs "for reducing the incidence of mental disorders of all types in the community ('primary prevention'), the duration of a significant number of those disorders which do occur ('secondary prevention'), and the impairment which may result from these disorders ('tertiary prevention')."

To a large degree, although not exclusively, emergency rooms are confronted with problems in secondary prevention—i.e., problems that tend to be resolved by reducing the duration of maladaptive behavior in relation to acute predicaments. Such predicament intervention has evolved, in part at least, from the military experience with "forward treatment" of behavioral decompensations in combat zones.

Military Applications

One of the earliest documented uses of short-term psychiatric intervention aimed at the prevention of hospitalization and chronic disability was during the Russo-Japanese War of 1904–1905, when the Imperial Russian Army pioneered the prompt care of "mental diseases" by psychiatrists as close to the men as the firing line (9). During World War I, the First Italian Army reported that results of treatment in psychiatric stations in the war zone were very satisfactory and that 60 percent of some forms of psychosis were cured within ten days (10). An even better experience was reported by the neuropsychiatric center of the French Second Army in 1916 (11).

Although the briefer American experience in World War I had been similar to that reported by the other Allied armies (12), an ill-advised trust in preinduction screening early in World War II delayed an adequate deployment of psychiatric workers in combat zones. As late as November 1943, only 18 percent of the Fifth Army neuropsychiatric casualties in Italy who returned to duty remained in the combat area. One year later, in November 1944, after an Army neuropsychiatric center had been established and psychiatrists had again been assigned to infantry divisions, 85 percent of the neuropsychiatric casualties who were returned to duty were assigned to the combat area (13).

Similar results were obtained during the Korean action; the concept of early intervention in combat areas was well reviewed from the epidemiological standpoint by Glass (14) in 1958. It is undeniable that a specific goal such as fitness to return to some type of duty in a combat zone can be achieved more rapidly and predictably by instituting treatment on the spot without relying on lengthy hospitalization. There is also sufficient evidence that lengthy hospitalization, especially when combined with removal of the patients from the areas in which the disabilities originated, tends to create persisting, chronic lowering of their overall functioning that may last the rest of their lives.

Civilian Settings

Although the causes of civilian predicaments and the goals for their adequate resolution are usually less clear than those of most combat predicaments, early intervention has been shown to be useful in civilian settings also as one way to reduce hospitalization and long-term disability (15, 16). When mental health services became preoccupied with speed and effectiveness, early intervention became one obvious tenet on which to build a different approach.

Now that the use of emergency rooms in general hospitals is greatly expanding, their traditional patterns of services are requiring revision. Emergency medicine is becoming a specialty. The American College of Emergency Physicians has grown to 3,300 members in five years (17). At the same time, the staff of many emergency rooms and the administrative staff of the hospitals within which these professionals work have begun only slowly and reluctantly to make any transitional changes in their self-images and role perceptions.

It would seem appropriate, therefore, to review the theory of crisis intervention as it has emerged over the last ten years and comment on its applicability to the work of the mental health professional (most often a psychiatrist) in the peculiar setting of an emergency room in a general hospital. We feel that a critique of existing theory from this particular point of view may also suggest modifications that could make the theoretical frame of reference more applicable to other situations where more mental health services may be needed.

Caplan's Crisis Theory

Caplan, in his *Principles of Preventive Psychiatry* (published in 1964), synthesized several trends of thought

[1] The use of the term "crisis" to mean periods of acute emotional distress is now well established in the literature. "Crisis" is defined in the *Oxford English Dictionary*, however, as "a vitally important or decisive stage in the progress of anything, a turning point." Erikson's (7) use of the word in his discussion of developmental phases is therefore correct. On the other hand, the word "predicament" is defined as "a state of being, condition, situation, position, especially an unpleasant, trying, or dangerous situation." It may be presumed that a person going through the stresses of a developmental crisis may be more predicament-prone than at other times. However, initial intervention, as in an emergency room, is obviously aimed more at the presenting predicament than at possible developmental crises in the background.

and action that had been developing for some time and formulated his version of crisis theory. Caplan's theory is partially rooted in the basic, still valid observation that little is known about the specific etiology of psychiatric syndromes. He saw the persisting need for refinement and development of operational frames of reference within which early, brief crisis intervention could be most effective and productive. Such conceptual models had to be based, according to Caplan, on factors of wide relevance to the psychological well-being of people and on factors that affect the vulnerability of specific groups as well. He suggested a long-term model and a short-term model. The long-term model presented a series of variables grouped under the headings of physical, psychosocial, and sociocultural supplies that may or may not be available. When such supplies are not available in some critical amount, predicaments arise that force some kind of change. Such changes may occur in large segments of the population or in an individual's characterological structure.

More important to our concern is Caplan's short-term model, which implies that sudden loss or threatened loss of basic supplies precipitates the individual into a state of crisis. These periods of change and crisis are seen as turning points, which may lead to an enrichment of the individual's ability to cope with stress or to a lower level of functioning, in accordance with the final outcome of the crisis.

"Crisis State"

Crisis state is described as a predictable process. In 1951, Tyhurst (18) spoke of three predictable phases of individuals' reactions to crisis, as observed in community disasters: 1) period of impact, 2) period of recoil, and 3) posttraumatic period. Caplan described four phases in crisis state; in essence, he subdivided Tyhurst's "period of recoil" into his phase two and phase three. In Caplan's phase two, failure of habitual problem-solving responses is associated with a further rise in tension and ineffectuality. In his phase three, there is a "mobilization of internal and external resources." The individual "uses novel methods to attack the problem, which may meanwhile have abated in intensity." If the predicament is reasonably well resolved, phase four is asymptomatic; Caplan believes, as Tyhurst does (19), that the individual is strengthened by his successful experience with unaccustomed ways of problem solving. If the predicament is not resolved, Caplan also agrees with Tyhurst that continuing disorganization may ensue in the final phase.

Caplan has stressed that the resolution of crises is influenced by the presence and the attitudes of significant others, particularly family members; by the sociocultural milieu within which the individual was born and lives; and by the attitudes of relevant community members. He has recognized that the history of the individual can be significant in terms of the symbolic meaning given to certain situations by past experiences. Caplan has pointed out that a person in crisis tends to elicit a rather blind, primordial helping reaction on the part of others. He has held to the somewhat questionable view that a person in crisis is more open to suggestion and more influenced by others during the critical period than at other times.

While Caplan has been widely quoted here and abroad (20–22), most articles on crisis theory have neither questioned his premises nor contributed materially to the further development of the theory. A few points can be made about this theoretical approach that seem to be shared by most, if not all, of the writers on the topic.

Comments on Caplan's Premises

The first point is that the emphasis is on the behavior of the individual thought to be experiencing the crisis, at least in terms of the amount of detail used in the descriptions of particular case situations. Although the social and interpersonal factors are usually acknowledged, the model does not seem to lend itself to their clear delineation.

In the second place, human crisis is assumed to be a universal phenomenon that can be described to a large extent independently of the specific characteristics of the individual and the situation. The model of homeostasis and the tension reduction theory as a form of motivation toward action are retained from basic psychoanalytic theory. As Taplin (23) has pointed out, however, such a theory based on homeostasis as a major goal is overly simplistic and "tenuous." It limits "psychological man to the status of reactor" and "cannot effectively characterize sections of human behavior such as growth, development, change, and actualization." A model that conceives of crisis primarily as a disturbance of homeostasis "cannot itself distinguish between adaptive and maladaptive imbalance." Perhaps, as Taplin suggests, "knowledge can be generated by moving away from clearly articulated theoretical systems to a looser, more descriptive consideration of a greater number of variables."

Third, although restoration of homeostasis is implicit in current theories of crisis intervention, there is also a basic assumption that crises can be seen as developmental points in most instances. Crises need not be seen simply as requiring the removal of a predicament; they can also be seen as occasions during which the resources of groups and individuals are often strengthened. Thus a new homeostasis, not just a return to the status quo, is sought. Such learning potential is particularly difficult to use or even recognize during Tyhurst's period of impact, when deep apathy often characterizes reactions to a serious predicament.

A major shortcoming in Caplan's synthesis is that the model he uses (availability versus shortage of "supplies") is similar to a simple input model such as might apply to nutrition and other somatic phenomena. This model can scarcely encompass the complex psychosocial interactions represented by predicaments or true crises. Although he talks of human potentials, Caplan tends to do so in a stimulus-response frame of reference that discounts spontaneity in individuals or groups of individuals in a disabling predicament. Adolf Meyer (24) once wrote:

"The philosopher who thinks that man will not act unless prompted by pain and conflicts maligns nature as does he who trusts only an arbitrarily hypothesized unconscious. We have a right to speak of a wider and perfectly uncomplicated spontaneity, just as we have a right to speak of natural growth as a differentiation of live individuals." In similar vein, Von Bertalanffy (25) pointed out more recently, in connection with general systems theory: "Even under constant external conditions and in the absence of external stimuli, the organism is not a passive but a basically active system. This applies in particular to the function of the nervous system and to behavior. It appears that internal activity rather than reaction to stimuli is fundamental." In these frames of reference, the individual's participation in developmental crises and episodic predicaments may be regarded as a temporary failure of primal "internal activity" to adapt adequately at some of the interfaces that exist between it and the numerous other significant systems that constitute a human being's psychosocial milieu.

SPECIAL THEORETICAL CONSIDERATIONS

With these general thoughts about the nature of crises and predicaments in mind, we can now approach the special case of emergency rooms in general hospitals.

From the beginning, we must continue to recognize that, even with due allowance for wide variations in physical setups and sophistication of programs, all emergency rooms are direct descendants of "accident" rooms. As in the past, traditional concepts of physical injuries and illnesses dominate the planning and implementation of services in these facilities. It is unrealistic to expect them even to approximate quantitatively the interdisciplinary resources of a well-planned, well-operating community mental health center. Nevertheless, qualitatively similar subtleties in making appreciations of total situations are obviously more badly needed and more attainable than is often recognized in the planning and operation of emergency rooms. Services primarily geared to anticipatory urgency sometimes falter when confronted with clients whose basic needs are somewhat obscured by their presenting complaints. Even as fundamental a skill as educated listening for brief but adequate periods is difficult to preserve in the charged atmosphere of a room called "Emergency." This is particularly true if space and staff are too small to cope with the average load and there are no reserve beds or personnel on which to fall back during peak load periods. For accreditation today, hospitals are required to have approved disaster plans. These plans have merit, but they are obviously conceived in the hope that the accredited hospital will have a program for coping with any major cataclysm which may strike the community served by that hospital. Unfortunately, they have little relevance to mobilizing resources to meet lesser surges of demand, which can hit the emergency room of the hospital far more frequently than do hordes of casualties from some horrendous community disaster.

Use of Emergency Rooms

McCarroll and Skudder (6) found that emergency room visits have increased as much as 600 percent since the 1940s, but they also found that 42 percent of these visits were not based on "true" emergencies. Such nonemergency visits illustrate the growing tendency in communities (particularly in urban areas [26]) for a significant number of people to identify any individual or group predicament as a problem that should be solvable through authoritative intervention by a member of the medical profession in a medical setting such as a hospital. Characteristically, clients present somatic complaints because of the long tradition that one must be "sick" to qualify for service from a hospital. Errera, LaPoidevin, Watson, Whitely, and their associates (2, 4, 5, 27, 28) reported that approximately five percent of the patients seen in an emergency room setting are clearly distinguished as needing psychiatric consultation or treatment. Yet we know that an additional large number of visits to emergency rooms are actually searches for help in resolving problems more related to adaptation and survival than reside in the somatic complaints that are presented (29).

Some of the public tend to see as legitimate reasons for an emergency room visit events and situations that average physicians and nurses are inclined to view as alien to their areas of expertise. The increased use of emergency rooms as a portal of entry to the health care system has thus caused an increasing conflict that goes beyond the pressures based only on the overcrowding of such emergency facilities. When significant discrepancies develop between the perception of medical roles by the professionals involved and the understanding of those roles by members of the public who are seeking services, these discrepancies in themselves tend to be identified as predicaments with psychiatric implications. The help of a psychiatric resource may then be sought, and this process will frequently eventuate in the identification of one member of a family or other community group as a mentally ill person.

Psychiatric Consultation

This observation is based on many experiences that consulting psychiatrists in general hospitals have reported. Meyer and Mendelson (30) stressed that two conditions are required for a professional to request a psychiatric consultation. These conditions are uncertainty about the nature of a patient's behavior and responsibility for doing something about the behavior. They also identified the operational group, consisting of the internist, the patient, the nurse, or the social worker, as the focus of the consultant's attention in identifying the problem and finding solutions. However, as mentioned by Lipowski (31) in his review, the patient-oriented and the consultee-oriented approaches are not incompatible with a situation-oriented approach; "a consultation is incomplete if the patient is considered apart from the social field in which he finds himself."

The crisis that leads to the request for a psychiatric

consultation has therefore been seen by general hospital consultants as primarily a group phenomenon to be interpreted first as such. It is interesting to note that crisis theory has been developed practically independently of the experience accumulated by psychiatric consultants in general hospitals. Yet it now seems obvious that the predicaments brought to the attention of an emergency room staff by the community and the requests for mental health consultations generated by such a staff should also be seen by the consultant primarily as the consequence of a complex psychosocial interaction. Although the individual medical and psychological problems of the identified patient deserve attention, they seldom seem to be the most relevant aspects of the field of forces that leads to the recognition of the predicament as a mental health problem. Caplan's theory does not offer adequately detailed guidelines regarding the systems represented in an emergency room crisis. We would like to suggest that, since emergency room crises occur at the point where a social milieu and a medical system meet, the theoretical observations and practical proposals of authors concerned with psychiatric consultations in general hospitals are more relevant to the transitional role of emergency rooms and to the function of the mental health consultant within them.

Characteristics of Crises

As we have mentioned, Caplan's theory also seems to imply that crises are universal phenomena that can be described independently of personality traits or other characteristics of the individual's psychological functioning. Such a theoretical approach does not seem to be particularly relevant to the predicaments seen in an emergency room. In a discussion of crisis prevention and the experiences of suicide prevention centers, Farberow (32) asked the very relevant question: "Crisis for whom?" His comments are so much to the point that we quote him: "Most of the writing to date has focused on typical crises occurring in the general population in the course of everyday life, with such precipitating events as kindergarten entry, loss or change of a job, death of a significant other, hospitalization of children and adolescents, and so on."

But it should be noted that the crises cited occur in relatively stable individuals and family groups and such people are not chronic users of emergency facilities. In Miller's study (33), the majority of emergency room clients was found to be in treatment or to have been recently in treatment in a medical or psychiatric facility or both. Lowy and associates (34), in a follow-up study of emergency psychiatric patients, found the following common characteristics, among others: high level of unemployment, high geographical mobility, and high incidence of previous psychiatric contact. From these limited data and our own experiences, it would seem that within the large and heterogeneous group of people using emergency ward facilities, a smaller and identifiable group requires a significant amount of the mental health consultant's time. A tentative identification of such a group can be given by again quoting Farberow. He described many clients as "persons whose histories are characterized by insecure, frequently changing interpersonal relationships, poor work history, frequent outbreaks of impulsive acting out, poor controls over impulses, present rather than future orientation, immaturity, excessive dependency, and other signs of instability" (32).

We feel therefore that the frequency and nature of individual crises and group predicaments are very much a function of the personality of the patient and the characteristics of the family and social group to which he or she belongs. Unless more attention is paid to such variables, we may continue to use theories of crises and intervention to handle events and people that hardly fit the theoretical model.

These concepts were well expressed in 1968 by Baxter and associates (35) in their definition of psychiatric emergencies:

> These emergencies may be broadly defined as disruptions in an individual's mental functions to a degree that prevents the interrelated adaptation of the patient himself, his family, and representatives of his community. Intervention is required to avoid permanent harm to these people or to avoid situational deterioration to a degree which would require much more professional attention at a later time.

As Miller pointed out:

> It is important to consider the patient and the social environment playing a role together in making a psychiatric emergency. In order to facilitate this point of view, I have introduced a concept called the ecological group, which refers to the patient and those people in the social environment with whom he has major dynamic relationships. It may include people in the family environment, the work environment, or the medical environment. In short, it cuts across various social systems to include all those people who currently provide sources of gratification and control for the patient and for whom he does the same (33, p. 927).

Miller also indicated:

> It is useful to emphasize the importance of extended emergency contact. If a disposition had to be made after one emergency meeting, much was still unclear. This was often due to the crippled thinking process of the anxious patient. It was a recurrent experience in our emergency service that when the patient had the opportunity to return for further interviews, his anxiety cleared sufficiently that he could begin to identify and master many of the problems himself, problems which he was unable to help the psychiatrist identify at the first visit (33, p. 931).

It should be emphasized also, however, that "emergency patients appear to achieve a quick resolution and terminate treatment on their own behest." Whitely and Denison (28) suggested that many patients seem motivated to receive "only casualty treatment." Schwarz and Fjeld (36) stressed the difficulty usually experienced in maintaining contact with chronic alcoholics, for instance, who impose great burdens on emergency rooms. Whether this is an expression of certain variables or a

consequence of the inadequacy of the services offered is still a debatable point.

Various studies have shown that initial diagnoses have little relation to the disposition of emergencies. This is not surprising when one recognizes that many predicaments are system-generated. Although the patients' symptoms may precipitate predicaments in social situations, the symptoms are often predominantly the consequences of the situations. Mountney and associates (37) found:

> So far as emergency action was concerned, many patients needed only a bed for the night. The psychiatric hospital may be entirely inappropriate, but police officers and house officers on casualty duty tend to become acutely anxious when faced with deviant behavior and demand dramatic action in psychiatric terms. The mental health social worker may disagree with their assessment, but the practical problem [of disposition] often dominates.

Kenyon and Rutter (38) recognized that behavioral management often took precedence over diagnostic issues in dealing with emergencies. Fisch and associates (39) commented that "the syndromes of acute emergencies are widely distributed in different diagnostic categories." Baxter and associates (35) found that "those patients having greater difficulty in communicating were significantly more frequently considered to be more dangerous to themselves and/or others." In the case of alcoholics, Schwarz and Fjeld (36) pointed out experiences commonly observed in other situations as well; descriptions of dangerous or unacceptable behavior were "much more frequently voiced by informants accompanying patients than by patients themselves." This differential influenced disposition. In the series reported by Schwarz and Fjeld, 30 percent of the unaccompanied patients were admitted to the alcoholism unit, whereas 47 percent of the patients accompanied by relatives or friends were admitted. Mendel and Rapport (40) also stressed the importance of social factors in decisions with regard to need for actual admission to hospitals.

We may conclude from our brief overview that the facts at hand support our interest in a better understanding of the social systems that seem to determine what will be labeled as a psychiatric emergency. Strong emphasis must be placed on the characteristics of the emergency ward staff and the role conflict generated in this group by the discrepancy between clients' expectations and traditional training and professional roles. It seems to us that such variables are most relevant to the process of identification, labeling, and disposition of critical behavioral events in an emergency ward. The experience gleaned from the literature also confirmed the fact that the personality characteristics of the clientele seem to be relevant to the issue of recurrent psychiatric emergencies. The general characteristics of the medical institution and its responsiveness to community demands as they can be interpreted by the patterns of help-seeking behavior by families and individuals also seem to be an obvious factor in whether or not the work of a mental health consultant will be repetitive and ritualistic or truly effective in reducing the incidence of system-generated crises.

PROGRAM DESIDERATA

It is evident that the intervention strategy of mental health professionals in the emergency room setting should include:

1. Consideration of the social forces and of the family or small group dynamics that have led to the identification of the predicament as a health crisis. Such consideration obviously requires familiarity with the social, economic, and cultural composition of the community.
2. Consideration of how the interaction between the clients and the emergency room professionals may have affected the situation in the direction of attenuating the problem or in the direction of worsening the predicament.
3. Consideration of the meaning of the whole situation to the individual and consideration of the significance of his maladaptive behavior in relation to the whole situation.

It should also be repeated that the ability of the mental health consultant to help significantly will be a function of the willingness and readiness of the medical institution to which he or she belongs to adapt its services to the needs of the clientele seen in the emergency room setting.

The Medico-Psycho-Social Team

To implement these multidimensional strategies, it would seem desirable, wherever and whenever possible, to weave into the texture of a general hospital's emergency room a medico-psycho-social team. The nucleus of this team would be a mature psychiatric nurse, a mature psychiatrist, and a mature social worker. It is to be hoped that these three professionals would have sufficient mutual respect that differences of opinion could be confined to immediate issues in a predicament without endless arguments over jurisdictional prerogatives. Ideally, such a team would have enough professional stature to earn and to hold the professional respect of the medical and surgical services in the hospital as well as of the responsible social agencies in the surrounding community.

Since maturity tends to be in short supply in all fields, each professional on this team would need sufficient numbers of deputies to ensure round-the-clock, seven-day-a-week coverage in the emergency room. If the core team is well coordinated professionally within itself, similar coordination among the deputies can be developed in time with adequate training.

By such a union of these three related disciplines in a functional unit, the many problems of clients can be appraised more promptly and adequately and early intervention can be initiated more effectively than is possible when only one model of service is available. Functioning in this manner, the mental health team can also contribute to a better understanding of predicaments by other sectors of the professional staff of an emergency room. Extended emergency contacts can obviously be more resourceful when multidisciplinary approaches are used. A

number of reports of the demonstrated utility of programs of this type have been published (41, 42).

The great majority of psychosocial predicaments encountered in emergency rooms do not require special physical facilities beyond the kind necessary to reduce the chronic pandemonium sometimes found in these settings. Severely disturbed behavior (such as that of a seriously intoxicated alcoholic or that of an excited catatonic) can be difficult to contain, however, without some physical resources for temporary seclusion and even restraint. Such behavior can also be very disrupting to the many other services that an emergency room is expected to provide. When possible, either a small psychiatric inpatient unit or at least a backup emergency ward should be made available. Johnson (43) regarded a "surfeit" of backup beds for intermediate care as an economy in the long run. Success in limiting care in such backup facilities to an intermediate phase is, of course, highly dependent on good working relationships with the families and with other agencies and resources in the community; if necessary, these can be rallied to participate in constructive, longer-term resolution of particular predicaments and crises. The amazing allocation of 50 percent of the space in a general hospital like the Pennsylvania Hospital in 1840 to the care of psychiatric patients (mentioned at the beginning of this paper) obviously reflected the serious limitations of alternate community resources at that time.

The core team of nurse, psychiatrist, and social worker in the emergency room obviously will have frequent need for current, accurate knowledge of what other agencies can offer in the way of relevant services for particular clients. Unfortunately, reliable information of this kind is seldom available from the brochures or program descriptions of social agencies. Only through personal contacts can the services of a resource agency be accurately appraised in relation to any one predicament with which one may be trying to deal. Like most helping facilities, emergency rooms can all too easily become overly aware of their own limitations and at the same time overly demanding that other related agencies do what they seem to claim to do in their annual reports. This curious form of organizational passive-dependency may eject a client into the infamous referral network where he rapidly becomes enmeshed in further referrals and counter-referrals. The client may prefer just to live with the original predicament, if this is at all feasible, rather than continue his search for help and change in the face of such bureaucratic complexities. More poignant than professional articles published on this sort of tragedy (44) was a popular article called "Pray for Barbara's Baby" published some years ago in the *Philadelphia Magazine* (45). The article documented how the referral network contributed materially to driving the younger members of some ethnic minorities into delinquent behavior just to get some attention paid to their needs as individual human beings.

REFERENCES

1. Morton TG, Woodbury F: The History of the Pennsylvania Hospital 1751–1895. Philadelphia, Times Publishing House, 1895, p 8
2. LePoidevin D, Reid AH: Emergency psychiatric referrals to the casualty department of a general hospital. Scot Med J 13:306–311, 1968
3. Shortliffe EC, Hamilton TS, Noroian EH: The emergency room and the changing pattern of medical care. New Engl J Med 258:20–25, 1958
4. Coleman JV, Errera P: The general hospital emergency room and its psychiatric problems. Am J Public Health 53:1294–1301, 1963
5. Errera P, Wyshak G, Jarecki H: Psychiatric care in a general hospital emergency room. Arch Gen Psychiatry 9:105–112, 1963
6. McCarroll JR, Skudder PA: Conflicting concepts of function shown in a national survey. Hospitals 24:35–38, 1960
7. Erikson EH: Growth and crises of the healthy personality. Psychol Issues 1:1–171, 1959
8. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964, pp 16–17
9. Richards RL: Mental and nervous diseases in the Russo-Japanese war. Military Surgeon 26:177–193, 1910
10. Morselli A: War psychiatry (abstract). Ment Hyg 1:438–439, 1917
11. Leri J: Psychiatry and neurology in the French Army, notes and comments. Ment Hyg 1:497–499, 1917
12. Salmon TW, Fenton M: Neuropsychiatry in the American Expeditionary Forces, in The Medical Department of the US Army in the World War. Edited by Ireland M. Washington, DC, US Government Printing Office, 1929
13. Hanson FR, Ranson SW: Statistical studies. Bulletin of the US Army Medical Department 9:191–204, 1949
14. Glass AT: Observations upon the epidemiology of mental illness in troups during warfare, in Proceedings of the Symposium on Preventive and Social Psychiatry Sponsored Jointly by the Walter Reed Army Institute of Research and the National Research Council, Washington, DC, April 15–17, 1957. Washington, DC, US Government Printing Office, 1958, pp 185–198
15. Kritzer H, Pittman FS III: Overnight psychiatric care in a general hospital emergency room. Hosp Community Psychiatry 19:303–306, 1968
16. Langsley DG, Flomenhaft K, Machotka P: Followup evaluation of family crisis therapy. Am J Orthopsychiatry 39:753–759, 1969
17. Directory for emergency physicians: introduction. Medical Opinion 2:27, 1973
18. Tyhurst JS: Individual reactions to community disaster: the natural history of psychiatric phenomena. Am J Psychiatry 107:764–769, 1951
19. Tyhurst JS: The role of transition states–including disasters in mental illness, in Proceedings of the Symposium on Preventive and Social Psychiatry Sponsored Jointly by the Walter Reed Army Institute of Research and the National Research Council, Washington, DC, April 15–17, 1957. Washington, DC, US Government Printing Office, 1958, pp 148–169
20. Bloom B: Perspectives on crisis intervention. Int J Psychiatry 6:380–382, 1968
21. Morrice JK: Emergency psychiatry. Br J Psychiatry 114:485–491, 1968
22. Porksen N: Uber krisenintervention. Z Psychother Med Psychol 20:85–94, 1970
23. Taplin JR: Crisis theory: critique and reformulation. Community Ment Health J 7:13–23, 1971
24. Lief A: The Common Sense Psychiatry of Dr. Adolf Meyer. New York, McGraw-Hill, 1948, pp 579–580
25. Von Bertalanffy L: General system theory: a critical review, in Modern Systems Research for the Behavioral Scientist. Edited by Buckley W, Rapoport A. Chicago, Aldine Publishing Co, 1968, pp 11–30
26. Klerman GL: Mental health and the urban crisis. Am J Orthopsychiatry 39:818–826, 1969
27. Watson JP: Psychiatric problems in accident departments. Lancet 1:877–879, 1969
28. Whitely JS, Denison DM: The psychiatric casualty. Br J Psychiatry 109:488–490, 1963
29. Nigro S: A psychiatrist's experiences in general practice in a hospital emergency room. JAMA 214:1657–1668, 1970
30. Meyer E, Mendelson M: Psychiatric consultations with patients on medical and surgical wards: patterns and processes. Psychiatry

24:197–220, 1961
31. Lipowski ZJ: Review of consultation psychiatry and psychosomatic medicine, I: general principles. Psychosom Med 24:153–171, 1967
32. Farberow N: Crisis prevention. Int J Psychiatry 6:382–384, 1968
33. Miller WB: A psychiatric emergency service and some treatment concepts. Am J Psychiatry 124:924–933, 1968
34. Lowy FH, Wintrob RM, Borwick B, et al: A followup study of emergency psychiatric patients and their families. Compr Psychiatry 12:36–47, 1971
35. Baxter S, Chodorkoff B, Underhill R: Psychiatric emergencies: dispositional determinants and the validity of the decision to admit. Am J Psychiatry 124:1542–1548, 1968
36. Schwarz L, Fjeld SP: The alcoholic patient in the psychiatric hospital emergency room. Q J Stud Alcohol 30:104–111, 1969
37. Mountney GH, Fryers T, Freeman HL: Psychiatric emergencies in an urban borough. Br Med J 1:498–500, 1969
38. Kenyon FE, Rutter ML: The psychiatrist and the general hospital. Compr Psychiatry 4:80–89, 1963
39. Fisch M, Gruenberg EM, Bandfield C: Epidemiology of psychiatric emergencies in an urban health district. Am J Public Health 54:572–579, 1964
40. Mendel WM, Rapport S: Determinants of the decision for psychiatric hospitalization. Arch Gen Psychiatry 20:321–328, 1969
41. Barton R, Whitehead JA: A psycho-geriatric domiciliary emergency service. Br J Psychiatry 114:107–108, 1968
42. Margolis PM, Andrew JM: The treatment of a psychiatric emergency in a university hospital setting. Mich Med 67:1227–1231, 1968
43. Johnson J: Psychiatric emergencies in the community. Compr Psychiatry 10:275–284, 1969
44. Ekdahl MC: Limitations of emergency services for mentally or emotionally disturbed mothers. Am J Public Health 60:1278–1288, 1970
45. Hunter K: Pray for Barbara's baby. Philadelphia Magazine, August 1968, pp 48–68

Questions of the Month

Directions: Each of the incomplete statements below is followed by four or five suggested completions. Select the *one* that is BEST in each case.

Question 1: The genetic theory of schizophrenia has most recently received support from a previously unexplored research method, namely
- (A) an investigation of the degree of concordance of schizophrenia in monozygotic twins
- (B) an investigation of the degree of concordance of schizophrenia in dizygotic twins
- (C) the determination of the likelihood of schizophrenia when one or both parents have the disorder
- (D) an investigation of the frequency of schizophrenia in children who are adopted in infancy and who have a biological schizophrenic parent
- (E) historical studies of the incidence of schizophrenia in relatively stable populations

Question 2: The most likely diagnosis in a socially isolated one-year-old child who lies expressionless much of the time, screams periodically, loses weight, and has poor sleep patterns is
- (A) childhood schizophrenia
- (B) anaclitic depression
- (C) mental retardation
- (D) infantile autism
- (E) Krabbe's disease

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 990. The references for the questions are supplied on page 994.)

The Current Status of Systematic Densitization

BY JOSEPH WOLPE, M.D., JOHN PAUL BRADY, M.D., MICHAEL SERBER, M.D., W. STEWART AGRAS, M.D., AND ROBERT PAUL LIBERMAN, M.D.

Systematic desensitization is indicated for phobias, obsessions, compulsions, and anxiety reactions that are maintained by anxiety-reducing defense mechanisms. The technique involves instruction in deep muscle relaxation, construction of an anxiety hierarchy, and stepwise pairing of relaxation with imagined anxiety-provoking scenes. The basic principle is that relaxation is incompatible with anxiety. Relaxation can be induced by direct instruction, drugs, carbon dioxide, hypnosis, positive imagery, and a metronome-conditioned method. More than 100 outcome studies indicate that systematic desensitization produces significantly better results than a variety of comparison therapies.

SYSTEMATIC DESENSITIZATION, one of the first of the behavior therapies, has been widely practiced for 14 years since its description by Wolpe (1) in 1958. This article summarizes the current clinical status of systematic desensitization by reviewing the method, its indications and contraindications, its effective elements, and its success as a treatment "package."

METHOD OF SYSTEMATIC DESENSITIZATION

In the standard systematic desensitization procedure, the emotional and cognitive effects of deep muscle relaxation inhibit anxiety while the anxiety-evoking stimuli are presented to the patient's imagination. Relaxation is taught first by a shortened version of Jacobson's method of progressive muscular relaxation (2); two to four muscle groups are dealt with during a ten- to 15-minute period at each of several sessions. During these sessions the stimulus controls of the patient's anxiety responses are also studied. Suppose, for example, that the patient responds with anxiety to being looked at by others. It may be found that the anxiety increases according to the number of people looking at him or according to their demeanor, their age or sex, or according to the vulnerability to criticism that he feels he incurs by some feature of the behavior he is exhibiting at that time, such as its presumptive awkwardness.

Whatever the relevant dimension, a list of situations involving it is made up and ranked according to the amount of disturbance each elicits. Such a ranked list is called a *hierarchy*. The items on the list may differ from each other by as simple a factor as their number or by complex factors that need to be specified in each case.

Another preliminary to systematic desensitization is to acquaint the patient with the *subjective anxiety scale*.[1] The therapist says: "Think of the worst anxiety you have ever had and call it 100; then think of being absolutely calm and call that zero. On the scale from zero to 100 you can at any time estimate your ongoing anxiety. And if your anxiety level changes, you can say by how much."

The technique of systematic desensitization proceeds as follows. The patient reclines in his own chosen position in a comfortable armchair or couch. He is asked to close his eyes and to relax in the way he has been instructed. His anxiety level must be down to zero (or very close to it) for an adequate counter-anxiety autonomic state to have been achieved. Having assured himself that the patient's anxiety level is close to zero, the therapist says: "Your eyes being closed, I am going to ask you to imagine a number of scenes. You will imagine them very clearly. The moment the image that I suggest is clearly formed, indicate it by raising your left index finger one inch." After a matter of seconds the finger will go up. The therapist waits about five seconds, then says: "Stop imagining that scene," and then: "By how much did that scene increase your anxiety level?" The patient will reply with a number on the subjective anxiety scale. After this, the patient is asked to relax for about 20 seconds before the therapist asks him to imagine the same scene again.

The second presentation of the scene is imagined for 20 to 30 seconds before it is "erased" by instructions from the therapist. In this manner of alternating between following the relaxation instructions and imagining the anxiety-evoking scene, the patient proceeds through the entire hierarchy. As each step in the hierarchy is mastered with relaxation in imagination, the patient is instructed to

The material in this article was presented by a panel of the authors as a Continuing Education session at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972. The authors are listed in the order of the sections of the article that each contributed.

Dr. Wolpe is Professor of Psychiatry, Temple University School of Medicine, Philadelphia, Pa.; Dr. Brady is Professor of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa.; Dr. Serber is Clinical Director, Atascadero State Hospital, Atascadero, Calif.; Dr. Agras is Professor and Chairman, Department of Psychiatry, University of Mississippi School of Medicine, Jackson, Miss.; and Dr. Liberman is Research Psychiatrist, Camarillo-Neuropsychiatric Institute Research Program, Camarillo State Hospital, Box A, Camarillo, Calif. 93010. Address reprint requests to Dr. Liberman.

[1] The use of the subjective anxiety scale is optional; however, a therapist must monitor the felt anxiety and observable muscle tension in a patient undergoing systematic desensitization to be certain that relaxation is maintained during the presentation of the scenes in the hierarchy.

generalize the results to the real-life situation. As successful generalization occurs and is reported, the therapist gives approval and acknowledgment of the patient's success.

INDUCTION OF RELAXATION

Several procedures have been described to hasten or facilitate relaxation in systematic desensitization. Patients who respond well to hypnotic suggestion may be aided in attaining a deeply relaxed state by hypnosis. A variety of drugs, including inhaled carbon dioxide (1), have also been used for this purpose. The most promising of these is sodium methohexital (Brevital), an ultrarapid-acting intravenous barbiturate. Subanesthetic intravenous doses of this drug are given slowly during the course of desensitization. There is evidence that the desensitization of anxiety responses proceeds more rapidly with this drug (3), and the amount of time required for preliminary training in relaxation can be greatly shortened (4, 5). Methohexital may hasten the deconditioning of anxiety not only by enhancing physical relaxation but also by a more direct pharmacologic action of inhibiting and hence counterconditioning the anxiety responses aroused by hierarchy scenes (6).

Another procedure for enhancing deep muscular relaxation, recently described by Brady (7), is metronome-conditioned relaxation. A rhythmic metronome of soft tone is inherently relaxing. Its relaxation-inducing properties are enhanced if the metronome's beats are associated with a deeply relaxed state induced by other means. This is accomplished by having the patient listen to a tape-recording pairing an abbreviated Jacobson progressive relaxation procedure with a metronome set at 60 beats per minute. In the tape the suggestions to "relax" and "let go" (of the muscles) are paced with the metronome's beats.[2] The patient listens to the 30-minute tape once daily while relaxing in a comfortable couch or reclining chair. After a short time (usually one or two weeks of daily practice) the metronome's beats alone come to function as conditioned stimuli and elicit (or facilitate) relaxation.

The metronome can then be used to rapidly induce a deeply relaxed state at the start of systematic desensitization sessions to decondition anxiety responses. In addition, the procedure can be used in other behavior therapy procedures in which deep muscular relaxation and the accompanying psychological calm are desirable. Thus metronome-conditioned relaxation has been used in the treatment of stuttering (to facilitate relaxation and calm in speaking situations usually associated with anticipatory anxiety and tension), insomnia (where muscular relaxation may lower arousal level and facilitate sleep), and psychophysiological disturbances brought on by episodic anxiety-tension states (7). A miniature transistorized metronome can be worn behind the ear and carried into the patient's natural environments, where real-life desensitization of anxiety-evoking situations can be accomplished.

[2] Thirty-minute conditioned relaxation tapes are available from Associated Auditory Instruments, Inc., 6796 Market St., Upper Darby, Pa. 19082.

INDICATIONS FOR SYSTEMATIC DESENSITIZATION

Before attempting to desensitize avoidance behavior motivated by anxiety, a therapist should carry out a careful analysis of the fear in question. He should ascertain the following:

Is the feared stimulus clearly specified or vague?

Does the situation in which the fear occurs restrict the patient's potential for practicing alternative behaviors?

Does the patient have a single fear or multiple fears?

Systematic desensitization works very well with fears and anxieties that are localized on objects or situations external to the individual and unrelated to interpersonal issues. Fears are more likely to be desensitized if they can be described and clearly defined as to time, place, and setting. Specific and well-demarcated fears are easily drawn up into coherent hierarchies, while diffuse and ill-defined fears are difficult to assemble hierarchically. One or two sessions may be necessary to clearly define the parameters of a particular anxiety-based avoidance problem. Individuals who are not able to clearly define the what, where, and when of their fears are not likely to benefit from desensitization.

Systematic desensitization is clearly indicated when a patient expresses a single or a few well-defined fears within a groundwork of adequate personal and social functioning. But patients with multiple fears and extensive problems and deficits in their social and emotional functioning are not good candidates for systematic desensitization. Psychotic and depressed patients may benefit from desensitization of their phobias but should be treated for their major disorders at the same time (8).

The person complaining of a fear must be capable of some degree of vivid imagery for experimental desensitization to be effective. Vivid imagery is the reconstruction of a scene in one's imagination with some sense of realness and clarity. It may require a number of practice sessions for some individuals to be able to vividly imagine scenes from their own lives with the affect that usually accompanies these scenes in real life. Patients who have had florid psychotic episodes and are in remission or who are labeled as schizoid are less capable of vivid imagery than others.

CONTRAINDICATIONS TO SYSTEMATIC DESENSITIZATION

There are no absolute contraindications to systematic desensitization. Patients who are unsuccessfully desensitized—that is, do not lose their specific fear and avoidance responses—do not as a result become more fearful or suffer other observable deleterious psychological or behavioral effects. The worst possible outcome of misap-

plied systematic desensitization is a lack of the desired results, that is, the persistence of the patient's specific fear. It is generally agreed by therapists of all persuasions that procedures which yield no positive results should be terminated so that another technique might be more effectively employed.

It should be emphasized that the following contraindications are not absolute; exceptions to each one do exist. The basis for reporting indications and contraindications remains in the realm of clinical experience rather than research data.

Systematic desensitization is less effective than other approaches with patients who exhibit psychotic symptomatology. One study reported no success with patients who had a history of psychosis even when they had not been acutely psychotic for at least six months before treatment (8).

Systematic desensitization is a less fruitful approach to a person's fears if these fears, after a systematic behavioral analysis, are found to be ill-defined and not clearly connected with specific stimuli: "I don't know what I'm afraid of. One day it's a bridge, the next day it's going to work." Patients who are panphobic or whose fears change their configuration frequently and without apparent external stimuli are poor candidates for systematic desensitization. The behavior therapy of choice for such patients is implosion, also called flooding (9).

The patient who persistently feels tense, uncomfortable, or unnatural when relaxation is induced (either by instruction or drugs) is probably a poor candidate for systematic desensitization. There are a number of patients who associate becoming relaxed in front of another person with being more vulnerable to being attacked or compromised in some way. Unless these concerns are allayed, such people are poor candidates for classical systematic desensitization. Equally important in decreasing the likelihood of the success of a desensitization procedure is the inability of a patient, after several practice trials, to vividly imagine scenes that, in life, make him anxious. Some of the above contraindications to systematic desensitization occasionally overlap. One sees patients who have had acute schizophrenic episodes, are unable to vividly imagine or relax, and who are also panphobic.

More subtle contraindications for systematic desensitization lie in specific fears that can be more appropriately treated by another technique, such as assertive training (10). Patients whose fears concern specific interpersonal anxieties, such as saying no to their children or telling a family member that they are unhappy with them, would usually respond more favorably to learning more expressive behaviors through assertive training. Family interactions in which an individual is always demeaned or work situations in which an individual is unable to stand up for himself are good examples of interpersonal encounters in which inadequate performances are instrumental in increasing anxiety. Such persons, instead of being desensitized to being insulted or accepting humiliation, would be treated more appropriately by learning a new behavioral repertoire that would in itself significantly reduce anxiety responses in interpersonal situations. When anxiety is associated with deficient social repertoires, including the inability to express frustration, anger, hurt, dominance, and affection, assertive training should be employed (10).

Systematic desensitization is not a feasible procedure when a patient is clearly achieving secondary gain or pays only lip service to overcoming his anxiety (*la belle indifference*). Agoraphobics frequently get family members or friends to accompany them to places that they "cannot" go to by themselves. A behavioral analysis usually reveals that the presence and assistance of family members, rather than the anxiety itself, are the reinforcers maintaining the avoidance behavior. In such cases other therapeutic approaches, such as contingency contracting with family members, can be of great value in modifying the avoidance behavior (11).

EFFECTIVE ELEMENTS IN DESENSITIZATION

Systematic desensitization consists of a core therapeutic procedure, namely, the patient visualizing feared scenes while deeply relaxed, together with an assortment of other procedures such as the therapist giving therapeutic instructions, noting and praising progress, and demonstrating how to deal with anxiety-provoking situations. At this point it is not clear which elements of the therapeutic procedure are most crucial for success; however, there is evidence that adding certain procedures to the core technique will facilitate therapeutic progress.

Instructions

The contribution of therapeutic instructions to desensitization therapy was examined in two studies (12, 13) in which subjects who were afraid of snakes served as phobic analogues. In both studies the main measure of outcome was a behavioral approach test conducted by experimenters not aware of which experimental group the subject belonged to. In the first study (12), one group was given therapeutic instructions and praised for progress; another was led to believe that they were taking part in a nontherapeutic experiment and were not told that desensitization was a therapy; and the last was an untreated control group. Only the group given therapeutic instructions differed significantly from the untreated control group, although the second group showed a significant change from the beginning to the end of the experiment. In the second experiment (13), designed to test the relative contributions of therapeutic instructions and therapist attention to progress, only instructions were found to have a significant effect. Again, however, the group that did not receive therapeutic instructions showed some benefit from the procedure, suggesting that removing therapeutic instructions reduces but does not entirely eliminate the effect of desensitization.

Feedback

During experiments with single cases of severe phobia it was noted that therapeutic instructions led to three behavior patterns: no improvement, transient improvement,

and continued improvement. This finding led to several attempts to identify therapeutic variables that might add to the effect of instructions and lead to continued improvement. One variable so identified was feedback of information concerning improvement. Thus, when her therapist stopped giving a claustrophobic patient information as to how long she had stayed in her feared situation (a small room), her rate of progress slowed dramatically (14). Reinstating feedback led to continued improvement. Similar findings were made in the case of a patient who was afraid of knives.

Reinforced Practice

Further work led to the identification of two more therapeutic variables. Reinforcement either in the form of praise (1) or tokens that could be exchanged for desired privileges led phobics to make progress in approaching their feared situation, while removal of such reinforcement reversed the trend. In a somewhat different experiment (15), phobics were found to make progress only when they practiced approaching their feared situation; this suggests that successful therapy of phobias consists of motivating patients to expose themselves to the feared situation, facilitating extinction of avoidance behavior. Work by Marks and his colleagues (9, 16) with implosion or flooding also suggests that direct exposure to the feared situation, perhaps in prolonged sessions, is the most effective therapy for phobias. Intriguingly, autonomic responses to the feared stimuli are not always extinguished, even when the patient is repeatedly able to face his phobic situation (17).

Muscle Relaxation

The role of relaxation in systematic desensitization was recently investigated in a series of single-case controlled studies (18). Dropping relaxation from the treatment regime slowed the patient's ability to visualize his approach to the feared object. This is in line with findings from studies which demonstrate that autonomic arousal from visualizing feared scenes diminishes more quickly in subjects who are relaxed than in those who are not relaxed. Surprisingly, in this study the removal of relaxation did not slow progress in approaching the *actual* phobic situation. One interpretation of these findings is that muscle relaxation enhances imaginal approach to the phobic situation, making it more likely that the patient will approach his situation in reality. Repeated exposure to elements of the phobic situation in reality then leads to extinction of avoidance behavior.

Modeling

Finally, Bandura and his colleagues (19) showed that a therapist modeling or demonstrating a nonfearful approach to the phobic object or situation enhances the patient's ability to expose himself to his feared situation.

Implications for Desensitization Therapy

These findings from well-controlled research strongly suggest that the efficiency of desensitization can be improved by making use of certain procedures in addition to pairing relaxation with the visualization of feared scenes. Attention should first be given to clearly defining the aims, rationale, procedures, and expected outcome of therapy. Arrangements should be made so that the patient can practice approaching his feared situation in reality in a graded manner. These arrangements not only allow the patient to be aware of his progress but also allow the therapist to praise him for that progress, thus making further exposure to the feared situation more likely. Considerable ingenuity may be required to arrange these procedures, but the research findings strongly suggest that doing so is very worthwhile.

OUTCOME STUDIES

In a review of the 75 outcome studies of systematic desensitization up to 1968, Paul (20) concluded that the findings were overwhelmingly positive for nearly 1,000 different clients treated by more than 90 different therapists. The range of anxiety-based problems reported to have responded to desensitization include delimited fears such as rat and snake phobias and test and public-speaking anxieties as well as more clinically relevant problems such as claustrophobia, acrophobia, agoraphobia, frigidity and impotence, and bronchial asthma. At the conclusion of his review of the desensitization literature, Paul stated:

> For the first time in the history of psychological treatments, a specific therapeutic package reliably produced measurable benefits for clients across a broad range of distressing problems in which anxiety was of fundamental importance. Relapse and symptom substitution were notably lacking, although the majority of authors were attuned to these problems (20).

Controlled studies substantiate the efficacy of systematic desensitization as a treatment method. Paul (21) carried out a study with 96 college students who had debilitating anxiety when performing in public; he distributed the students randomly among five treatment and control groups. Desensitization was compared with insight-oriented psychotherapy and an attention-placebo approach. The therapists were experienced in insight-oriented therapy and treated students from each of the groups after receiving training in desensitization. The treatment for all groups consisted of five one-hour sessions each week. A test battery including behavioral ratings, self-reports, therapist reports, and physiological measures was administered before and during treatment and one week, six weeks, and two years after treatment. In all comparisons, desensitization was consistently superior to either attention-placebo or insight-oriented therapies, while the latter two procedures did not differ significantly from each other. Significant improvement two years after termination of the brief therapy was maintained in 85 percent of the students receiving desensitization compared with 50 percent of those receiving insight-oriented or attention-placebo therapy. No evidence was found for symptom substitution; in fact, the treatment effects seemed to generalize to other fears (22).

Moore (23) performed a controlled comparison of desensitization with relaxation alone and relaxation plus direct suggestion on 12 asthmatics. The investigator was the sole therapist; while this allows for therapist bias as a possible confounding factor, the plausibility of such a bias is low because of the counterbalanced, time-sample nature of the design. Desensitization produced significantly greater improvement in maximum peak flow, a measure that reflects airway resistance.

Eight other studies were cited by Paul (20) as having enough methodological controls to establish an independent cause-effect relationship between desensitization and improvement in symptoms. Gelder and associates (24, 25), in a series of semicontrolled studies, showed statistically that desensitization is significantly more effective than insight-oriented therapies for a wide variety of clinical phobias. Liberman and Smith (26), using a multiple baseline design, demonstrated a cause-effect relationship between desensitization and improvement in four phobias in a single patient.

DiLoreto (27), in an extremely well-designed and well-controlled study, found that systematic desensitization was significantly more effective than either client-centered or rational-emotive therapy with college students who scored high on interpersonal anxiety scales. Two graduate student counselors employing desensitization were one-third more effective with their clients than the best counselors using either client-centered or rational-emotive approaches, and they were four times more effective than counselors giving attention-placebo treatment. Results at a three-month follow-up mirrored those at termination: the systematic desensitization group maintained its superior outcome over the other two groups. There was also a substantial amount of generalization to general anxiety scales when individuals showed a marked reduction in interpersonal anxiety. There was no evidence of symptom substitution.

Since Wolpe described desensitization in 1958, uncontrolled and controlled studies of this treatment approach have abounded. It has been empirically evaluated perhaps more than any other treatment modality in psychiatry. What has happened with this treatment procedure illustrates the growth of the science of behavior therapy from laboratory studies with animals to uncontrolled clinical trials of effectiveness to the controlled experiments that mark the current literature.

However, systematic desensitization should be seen as only one technique of, rather than synonymous with, the larger field of behavior therapy. Behavior therapists incorporate systematic desensitization into their overall therapeutic framework, which is based on behavioral specification, reliable measurement, and an experimental analysis of behavioral problems.

REFERENCES

1. Wolpe J: The Practice of Behavior Therapy. New York, Pergamon Press, 1969
2. Jacobson E: Progressive Relaxation. Chicago, University of Chicago Press, 1938
3. Mawson AB: Methohexitone-assisted desensitization in treatment of phobias. Lancet 1:1084–1086, 1970
4. Brady JP: Systematic desensitization, in Behavior Modification: Principles and Clinical Applications. Edited by Agras WS. Boston, Little, Brown and Co, 1972, pp 127–150
5. Brady JP: Brevital-aided systematic desensitization, in Advances in Behavior Therapy 1969. Edited by Rubin RD, Fensterheim H, Lazarus AA, et al. New York, Academic Press, 1971, pp 77–83
6. Brady JP: Drugs in behavior therapy, in Psychopharmacology: A Review of Progress 1957–1967. Edited by Efron DH. Public Health Service Publication 1836. Washington, DC, US Government Printing Office, 1968, pp 271–280
7. Brady JP: Metronome-conditioned relaxation. Br J Psychiatry (in press)
8. Serber M, Nelson P: The ineffectiveness of desensitization and assertive training with hospitalized schizophrenics. Journal of Behavior Therapy and Experimental Psychiatry 2: 1–3, 1971
9. Marks IM, Boulougoris J, Marset P: Flooding vs desensitization in the treatment of phobic patients: a crossover study. Br J Psychiatry (in press)
10. Lazarus AA, Serber M: Is systematic desensitization being misapplied? Psychol Rep 68:215–218, 1968
11. Liberman RP: A Guide to Behavioral Analysis and Therapy. New York, Pergamon Press, 1972
12. Leitenberg H, Agras WS, Barlow DH, et al: Contribution of selective positive reinforcement and therapeutic instructions to systematic desensitization therapy. J Abnorm Psychol 74:113–118, 1969
13. Oliveau DC, Agras WS, Leitenberg H, et al: Systematic desensitization, therapeutically oriented instructions and selective positive reinforcement. Behav Res Ther 7:27–33, 1969
14. Leitenberg H, Agras WS, Thompson LE, et al: Feedback in behavior modification: an experimental analysis in two phobic cases. J Appl Behav Analysis 1:131–137, 1968
15. Leitenberg H, Agras WS, Edwards JA, et al: Practice as a psychotherapeutic variable: an experimental analysis within single cases. J Psychiatr Res 7:215–225, 1970
16. Marks IM: Flooding and allied treatments, in Behavior Modification: Application of Principles and Procedures. Edited by Agras WS. Boston, Little, Brown and Co, 1972, pp 186–204
17. Leitenberg H, Agras WS, Butz R, et al: Relationship between heart rate and behavioral change during the treatment of phobias. J Abnorm Psychol 78:59–68, 1971
18. Agras WS, Leitenberg H, Barlow DH, et al: The role of relaxation in systematic desensitization therapy. Arch Gen Psychiatry 25:511–514, 1971
19. Bandura A, Grusee JE, Menlove FL: Vicarious extinction of avoidance behavior. J Pers Soc Psychol 5:16–23, 1967
20. Paul GL: Outcome of systematic desensitization, in Behavior Therapy: Appraisal and Status. Edited by Franks CM. New York, McGraw-Hill Book Co, 1969, pp 63–159
21. Paul GL: Insight vs Desensitization in Psychotherapy: An Experiment in Anxiety Reduction. Stanford, Calif, Stanford University Press, 1966
22. Paul GL: Insight vs desensitization in psychotherapy two years after termination. J Consult Psychol 31:333–348, 1967
23. Moore N: Behaviour therapy in bronchial asthma: a controlled study. J Psychosom Res 9:257–276, 1965
24. Gelder MG, Marks IM: Severe agoraphobia: a controlled prospective trial of behaviour therapy. Br J Psychiatry 112:309–319, 1966
25. Gelder MG, Marks IM, Wolff HH: Desensitization and psychotherapy in the treatment of phobic states: a controlled inquiry. Br J Psychiatry 113:53–73, 1967
26. Liberman RP, Smith V: A multiple baseline study of desensitization. Behav Ther 3:597–603, 1972
27. DiLoreto AO: Comparative Psychotherapy: An Experimental Analysis. Chicago, Aldine-Atherton, 1971

Influence of Affective States and Psychoactive Drugs on Verbal Learning and Memory

BY GEORGE M. HENRY, M.D., HERBERT WEINGARTNER, PH.D., AND DENNIS L. MURPHY, M.D.

The authors found evidence of impaired performance on serial and free recall verbal learning tasks during depression and mania. Treatment with L-dopa and L-tryptophan significantly improved performance on these tasks, while imipramine, lithium carbonate, and alpha-methyl-para-tyrosine treatments had no effect. These results should be taken into account when using psychotherapeutic approaches designed to teach new response patterns to patients with affective disorders.

A NUMBER OF STUDIES have pointed toward subtle impairments of cognitive functioning that occur during episodes of the major affective illnesses. Distractibility (1), altered attention span (2), altered conceptual styles (3, 4), and different patterns of cortical evoked responses (5) have been related to depression and mania. Recently we have found evidence linking alterations in learning, memory, and associative processes to changes in patients' clinical states during mania and depression (6, 7) and to the treatment of these states with psychoactive drugs (8).

It has also been suggested that the affective disorders are linked to changes in the concentrations of brain monoamines, especially norepinephrine, dopamine, and serotonin (9–13). Evidence from several sources indicates that learning and memory may be affected by these amines. In rodents, for example, maze performance and conditioned avoidance responses were improved by the administration of L-dopa, L-tryptophan, amphetamine (under certain circumstances), and other drugs that are thought to act by increasing the effective concentrations of brain biogenic amines. In contrast, drugs that inhibit amine synthesis or deplete amine stores impair some forms of learned behavior (14–16). Patients suffering from Parkinson's disease have exhibited improvements in memory (17) and performed better on intelligence tests, including tests of memory (18–20), after they have been treated with L-dopa.

This paper will bring together, from our previous work (6–8) and more recent studies, data that indicate a relationship between memory and amine concentrations in affective disorders and that support the hypothesis, taken from animal studies, that biogenic amines play a substantial role in arousal, emotion, and learning (15, 21, 22).

Dr. Henry is Assistant Professor of Psychiatry, University of Kentucky College of Medicine, Lexington, Ky. 40506. Dr. Weingartner is Professor of Psychology, University of Maryland, Baltimore, Md. Dr. Murphy is Chief, Clinical Research Unit, Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health, Bethesda, Md.

METHOD

The subjects were hospitalized patients diagnosed as having bipolar manic-depressive psychosis or unipolar depressive psychosis. These diagnoses were made after we obtained detailed individual and family histories, observed the patient two weeks or longer without psychoactive drugs, and gave psychological tests.

For all our studies, two learning tests (23) were used: a serial learning task in which equivalent lists of eight random words were presented orally for repetition in correct order for six trials and a free recall task in which equivalent lists of 22 common words were presented for recall in any order and then repeated with the last half of the lists presented first.

The storage of information in memory may be viewed as a series of discrete steps that includes storage in a sensory register (primarily an attentional stage), storage in short-term memory stores (measured by immediate recall of information), and recoding the information in short-term stores into a form that can be held in long-term storage (24, 25). This model of memory prompted us to view our learning tasks in the following way. The first trial of the serial learning task was considered an example of immediate recall and was therefore analyzed separately from the subsequent trials. An increment in learning on subsequent trials indicated that the learning from trial one had shifted from short-term to long-term memory storage.

On the serial learning task, producing an incorrect sequencing of word pairs was defined as an error. On the free recall task, intrusions (i.e., words not presented to the subject) were considered errors of commission, while words presented but not recalled were errors of omission.

A standard word association test was used to measure the patient's associative pattern and to see whether changes in verbal association were related to changes in his clinical state during drug treatment (26). Single stimulus words from random lists of 20 nouns, adjectives, and verbs from the Palermo-Jenkins Word Association Norms (27) were presented with instructions to respond with the first word that came to mind. Responses were called "high-frequency" if they were given at least 50 times by subjects in the sex-appropriate control group

and "idiosyncratic" if they were never given by the control group (N=500) (27).

The tests were administered twice weekly by an investigator who, like the patients and clinical raters, was ignorant of whether the patients were receiving the active drug or its placebo. Statistical methods included paired t tests, analysis of variance, and regression analysis.

Clinical State

The dependent variable in evaluating the clinical state was a change in clinical behavior observed by independent raters using the Bunney-Hamburg 15-point ward rating scale (28), on which a rating of one indicates the absence of mania and 15 the presence of severe mania. Because we compared the mean results of testing during periods of intensified mania or depression, each subject served as his own control. The behavioral conditions for comparing manic and nonmanic periods are described elsewhere (6). Periods of relatively greater depression were defined as test days when the patient was given depression ratings of seven or more on the depression scale, while periods of relatively less depression were days when the ratings were below seven.

Amine Precursors and Other Drugs

In measuring the effects of treatment with amine precursors and blockers or other psychoactive drugs on memory functioning, we compared results between test days when patients were receiving placebo and days when they received daily doses of 5.5 ± 0.6 gm./day of L-dopa, 8.6 ± 0.6 gm./day of L-tryptophan, 2.7 ± 0.2 gm./day of alpha-methyl-paratyrosine (αMPT), 1.2 to 2.1 gm./day of lithium carbonate, and 100 to 250 mg./day of imipramine. Since treatment with L-dopa and imipramine is associated with the induction of hypomania in susceptible patients (22, 29) and since manic behavior had already been found to influence learning (6), patients' responses were excluded from the analysis when mania was present, i.e., when ratings for mania were greater than one on the 15-point scale.

RESULTS

Effects of Clinical State on Learning

Mania. The results from the manic patients have been reported previously (6), but are summarized here (see table 1) for comparison with the other results that follow. During mania, patients showed impaired serial learning on the second and subsequent trials, but not on the first trial of either learning task. They produced significantly more errors and tended to retain their incorrect word sequences in spite of repeated reading of the correct word sequences. On the free recall task they recalled 33 percent fewer words than during their nonmanic periods. In addition manic patients made significantly more errors of commission.

Thirty-three percent of the word associations produced during mania were idiosyncratic responses, a striking result when contrasted with the control testing findings of 11 percent and reported results from several studies with acute and chronic schizophrenic patients of 18 percent (30–33). In addition, the high-frequency association responses from manic patients had a more rapid rate of turnover on retesting 20 minutes later. The patients were able, however, to recall some of the idiosyncratic associations they had made and to give the same associations during subsequent manic episodes even though they did not give them when they were nonmanic.

TABLE 1

*Summary of Changes in Verbal Learning and Associations in Affective Disorders**

Task	Bipolar		Unipolar
	Mania	Depression	Depression
Serial learning			
Correct responses			
Trial 1	n.s.	n.s.	n.s.
Trial 2–6	decrease	decrease	decrease
Errors	increase	n.s.	n.s.
Free recall learning			
Correct responses	decrease	n.s.	decrease
Errors			
Commission	increase	n.s.	n.s.
Omission	n.s.	n.s.	increase
Word association			
Idiosyncratic responses	33%	15% (n.s.)	15% (n.s.)
Turnover of responses	increase	n.s.	n.s.

*Changes are significant ($p < .05$) unless noted by n.s.

Depression. During depression, the 25 depressed patients (14 bipolar and 11 unipolar) showed a decrease in serial learning (see table 1) on the second through sixth trials ($F = 8.38$; d.f. = 1, 20; $p < .01$) in comparison with their own individual performance on test days when they were significantly less depressed (mean depression ratings of 8.4 ± 0.3 and 4.8 ± 0.1, respectively; $p < .001$). However, there was no significant difference on first trial learning of the word lists between the depressed and nondepressed states. An analysis of variance for the serial learning results using a factorial design with four variables (unipolar versus bipolar depression, subjects, high versus low ratings for depression, and learning trials) revealed statistically significant differences attributable not only to the variable of high versus low depression ratings but also to the unipolar-bipolar variable ($F = 5.08$; d.f. = 1, 20; $p < .05$).

On the free recall task (table 2) depression was again associated with statistically significant impairment in memory for the 25 patients ($p < .01$, paired t test). When the two subgroups were considered separately, the poorer recall by the bipolar patients while depressed was not statistically significant, while the unipolar patients' performance was significantly impaired when they were depressed ($p < .01$). Figure 1 shows a regression analysis for these 11 unipolar patients which indicates that, as depression ratings increase, a decrease occurs in those responses which were previously given correctly and were retained on the

TABLE 2
Free Random Recall Responses During Depressed and Nondepressed Periods in a Group of Bipolar and Unipolar Depressed Patients (N=25)

Trial	Correct Responses: Nondepressed (Mean ± S.E.)	Correct Responses: Depressed (Mean ± S.E.)	Significance
1	5.9 ± 0.4	5.0 ± 0.3	$p<.01$
2	8.2 ± 0.4	6.7 ± 0.5	$p<.01$

second presentation of the word list. The unipolar patients also made significantly more errors ($p<.02$) than when they were relatively nondepressed; these errors were predominantly of the omission type ($p<.05$).

In contrast to the results obtained for mania, we noted no significant changes in word association patterns during depression in either the bipolar or unipolar patient groups. The means and standard errors for the high frequency word responses during control and depression periods were 9.4 ± 0.6 and 10.2 ± 0.6 associations, respectively, for the 14 bipolar patients. Similarly, the idiosyncratic word association responses for control and depression period testing were 2.8 ± 0.5 and 3.2 ± 0.5 words, respectively, for the bipolar patients and 2.3 ± 0.8 and 2.8 ± 0.5, respectively, for the unipolar group.

Effects of Drugs on Verbal Learning

The treatment of eight depressed patients with L-dopa and ten depressed patients with L-tryptophan was associated with statistically significant improvement of verbal learning. The administration of L-dopa led to significantly improved performance after the first trial of serial learning (table 3) and on the free recall task (table 4). Treatment with L-tryptophan, on the other hand, was associated with a statistically significant improvement in serial learning (table 3) but not in free recall performance (table 4). As with the findings during periods of change in manic or depressive states, there were no significant differences between performance on the first serial learning trials during treatment with drugs and baseline ($p>.10$).

As reported elsewhere (34, 35), the clinical trials with L-dopa and L-tryptophan did not indicate that these drugs were useful as antidepressants; for the patients included in this study, there were no significant group differences ($p>.10$) in depression ratings when the L-dopa and L-tryptophan periods were compared with the placebo treatment periods. No changes were observed in the word association patterns of the patients treated with these amine precursors.

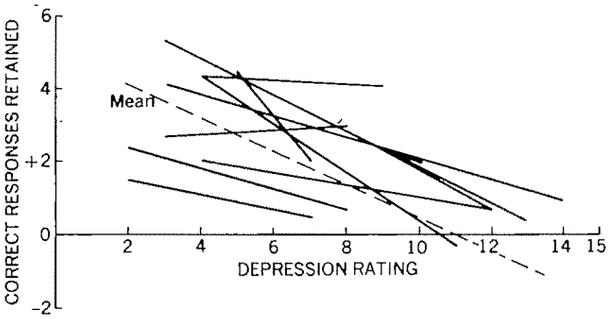
No significant changes in any of the learning tasks occurred in the group of seven depressed patients who received αMPT (8).

Those depressed patients studied before and during treatment with lithium carbonate ($N=12$) or imipramine ($N=6$) exhibited slight improvement on the serial learning and free recall measures, but the changes were not statistically significant for either group. For example, the free recall responses on the second trial were 7.4 ± 0.4 and 8.9 ± 0.7 words in the placebo and lithium treatment conditions, respectively ($t = 1.18$, $p>.10$), and 8.1 ± 0.7 and 10.1 ± 0.9 words in the placebo and imipramine treatment conditions, respectively ($t = 1.72$, $p>.10$). However, rated improvement in depression occurred both in the lithium-treated group ($p<.05$) and in the group treated with imipramine ($p<.01$).

DISCUSSION

Most current memory models describe remembering and forgetting in terms of discrete stages that include a sensory store, short-term storage characterized by a limited information capacity of about 7 ± 2 items and by rapid memory decay, and long-term memory or storage, which is dependent on repetition and association with previously organized and coded information already in memory (24, 25, 36, 37). In our studies neither mania, depression, nor treatment with any of the drugs that affect biogenic amines had any effect on a typical measure of short-term memory, i.e., on immediate recall of the first trial of an eight-word serial learning task. Despite the fact that neither mania nor depression was associated with short-term memory deficits, both groups of subjects displayed learning impairments on the serial learning task. This effect can best be viewed as an inability to shift information from short- to long-term storage. Pretreatment with the biogenic amine precursors was associated with improvement in this function. Generally similar effects were noted on the free recall task, which presents more items as stimuli than can be placed in short-term memory and recalled immediately. Organizing stimuli by association is particularly important in memory tasks that require the storage or learning of large amounts of information (24, 25, 36, 37). Consequently, the results on both tests suggest that mania and depression, as well as treatment with biogenic amine precursors, produce memory changes after information

FIGURE 1
*Free Recall During Depression in Unipolar Patients: Decrease in Mean Correct Responses with Increase in Depression Ratings**



*Regression lines were calculated by the least-squares method for the individual patient's responses.

TABLE 3
Effects of Biogenic Amine Precursors and Blocking Agents on Serial Learning in Depressed Patients: Analysis of Variance for Correct Responses

Agent	F Score	d.f.	Significance
L-dopa	8.6	1,7	$p<.05$
L-tryptophan	8.3	1,9	$p<.05$
Alpha-methyl-para-tyrosine	1.5	1,6	n.s.

has entered a short-term store, at a point when the information is being transferred into long-term memory stores.

Mania, with its accelerated psychomotor activity, fluctuating affect, flight of ideas, distractibility, and poor judgment, is now known to be accompanied by a pattern of idiosyncratic verbal associations and the increased turnover of other associations. This effect on verbal association patterns would be expected to have marked effects on memory functions, particularly those involved in the encoding and transfer of information from short- to long-term memory and in the production and processing of retrieval cues needed for recall. The manic individual is connecting newly acquired information with associations that are idiosyncratic and relatively unstable and therefore less accessible as retrieval cues. However, even though he cannot learn the task presented to him by the experimenter, the manic patient does seem relatively able to recall his own idiosyncratic associations. This suggests the possibility that the state-dependent learning during mania is similar to that shown to occur with a number of different drugs (38–41). The "state" particular to mania may be tentatively considered one of behavioral hyperarousal (22).

On the other hand, depression, which in some but not all patients may involve underarousal, is clearly associated with a different pattern of learning impairment. Unlike the alterations in mania, the errors are of omission, rather than commission, and there is no change in word association patterns. Since the unipolar depressed group showed these results most clearly, perhaps a process that is different from that found in the bipolar patients is involved. Other data indicate different behavioral and psychological characteristics of depression in unipolar and bipolar patients (2, 42, 43). The different learning responses shown by the bipolar and unipolar groups in an analysis of variance suggest such a distinction. However, in this study, the group of depressed bipolar patients had symptoms that were slightly less severe, as determined by the clinical ratings, than the unipolar group did; the group mean depression ratings during test periods were 7.7 ± 0.2 and 9.2 ± 0.6, respectively.

The results of our comparisons during different clinical states therefore indicate that learning ability is relatively normal during relatively normal clinical conditions and that deterioration of memory function develops with behavioral change toward either mania or depression. Viewed with reference to the degree of behavioral arousal, normal learning is associated with normal arousal while impaired learning characterized by an increase in errors of omission is associated with underarousal during depression, and impaired learning characterized both by more errors of commission and idiosyncratic word associations is related to hyperarousal during mania. These observations define an inverted-U function for arousal and learning in affective illness that is consistent with the conclusions of Malmo and Duffy concerning a wide variety of relationships between arousal and performance (44, 45).

The improvements in memory functions resulting from treatment with L-dopa might also be related to the changes in arousal that this drug brings about (8). As others have suggested with regard to parkinsonian patients who showed improvement in cognitive functioning when treated with L-dopa (17–20), the depressed patients in our study may have been relatively underaroused before treatment. Several of the depressed patients exhibited moderate psychomotor retardation. The improvement in learning performance after treatment with L-dopa could then be viewed as a return to a more normal level of memory functioning by these relatively underaroused patients. There are no reports on the effect of these amine precursors on learning in normal human subjects, but animal studies indicate that learning improvement after treatment with L-dopa is less striking in normal animals than in those depleted of catecholamines and indoleamines by pretreatment with reserpine (46).

Improved functioning in depressed patients after administration of L-tryptophan is more difficult to understand in terms of arousal, since there is little evidence that L-tryptophan produces measurable change in behav-

TABLE 4
Effects of Biogenic Amine Precursors and Blocking Drugs on Free Random Recall in Depressed Patients: Paired T Test for Correct Responses

Trial	L-dopa			L-tryptophan			Alpha-methyl-paratyrosine		
	Placebo	Drug	p	Placebo	Drug	p	Placebo	Drug	p
Trial 1	5.6 ± 0.8	6.3 ± 0.9	n.s.	5.2 ± 0.4	5.8 ± 0.6	n.s.	5.3 ± 0.5	5.2 ± 0.3	n.s.
Trial 2	7.6 ± 1.1	10.9 ± 1.3	$<.01$	7.1 ± 0.5	7.8 ± 0.9	n.s.	7.1 ± 0.5	7.2 ± 0.6	n.s.
Increment (T_2–T_1)	2.1 ± 0.6	3.9 ± 0.6	$<.001$	1.9 ± 0.4	2.0 ± 0.4	n.s.	1.8 ± 0.5	2.0 ± 9.5	n.s.

ior (35). At least one study with rats indicated improved performance in swimming a T maze when L-tryptophan was given in amounts sufficient to increase brain serotonin by 40 percent (47). The failure of αMPT to impair learning in our subjects may also result from a preexisting state of impaired learning or from the amine depletion that is hypothesized to exist during depression (9–12).

It is important to ask whether improved memory functioning, which is postulated to result from a shift to a more normal state of central arousal, occurs as a consequence of the stabilized clinical state or whether it is more specific and hence separable from general clinical improvement. For example, the improved learning ability that has been demonstrated in parkinsonian patients treated with L-dopa has been attributed to the overall improvement in their clinical condition (17–20). In our study with patients who have affective disorders there is evidence that improvement in memory may be independent of clinical improvement. Those drugs which clearly alleviated depression—imipramine and lithium—were not associated with significantly improved learning on our tests. However, treatment with L-dopa and with L-tryptophan did not significantly change depression ratings but produced improvements in learning. Therefore, at least for patients with affective disorders, there seems to be an amine-related learning effect that is separate from observable changes in clinical behavior.

Although problem solving and insight in psychotherapy are more complex processes than those measured by the learning tests used in this study, the relatively simple processes involved in these tasks may have implications for treatment. Therapeutic approaches that are intended to modify behavior should take into account the patient's difficulties in storing and retrieving new information. For instance, impaired learning by the manic patient whose recall is limited primarily to information that has personal meaning for him may limit his capability to learn new response patterns in psychotherapy. Similarly, it may be somewhat difficult to teach a depressed patient new behavioral patterns because of the memory impairment associated with depressed states. Both patient groups may need to be reinforced to strengthen certain desirable responses they may already possess. In both extremes of behavioral arousal, those conditions might be sought, perhaps pharmacologically, which would stabilize arousal at a more normal level.

REFERENCES

1. Kraepelin E: Manic-Depressive Insanity and Paranoia. Edinburgh, ES Livingstone, 1921
2. Perris C: A study of bipolar (manic-depressive) and unipolar recurrent depressive psychoses. Acta Psychiatr Scand 42 (Suppl 194):1–189, 1966
3. Beck AT: Depression: Clinical, Experimental, and Theoretical Aspects. New York, Harper & Row, 1967
4. Salzman LF, Goldstein RH, Atkins R, et al: Conceptual thinking in psychiatric patients. Arch Gen Psychiatry 14:55–59, 1966
5. Buchsbaum M, Goodwin F, Murphy D: AER in affective disorders. Am J Psychiatry 128:19–25, 1971
6. Henry GM, Weingartner H, Murphy DL: Idiosyncratic patterns of verbal learning and word association during mania. Am J Psychiatry 128:564–574, 1971
7. Henry GM, Weingartner H, Murphy DL: Altered cognitive functions during depression and mania. Presented at the Fifth World Congress of Psychiatry, Mexico City, Nov 28–Dec 4, 1971
8. Murphy DL, Henry GM, Weingartner H: Catecholamines and memory: enhanced verbal learning during L-DOPA administration. Psychopharmacologia 27:319–326, 1972
9. Bunney WE Jr, Davis JM: Norepinephrine in depressive reactions. Arch Gen Psychiatry 13:483–494, 1965
10. Schildkraut JJ: The catecholamine hypothesis of affective disorders: a review of supporting evidence. Am J Psychiatry 122:509–522, 1965
11. Glassman A: Indoleamines and affective disorders. Psychosom Med 31:107–114, 1969
12. Bunney WE Jr, Murphy DL, Goodwin FK, et al: The switch process from depression to mania: relationship to drugs which alter brain amines. Lancet 1:1022–1027, 1970
13. Murphy DL, Goodwin FK, Brodie HKH, et al: L-dopa, dopamine, and hypomania. Am J Psychiatry 130:79–82, 1973
14. Oliverio AL: Neurohumoral systems and learning, in Psychopharmacology: A Review of Progress, 1957–1967, Public Health Service Publication No 1836. Edited by Efron DH. Washington, DC, US Government Printing Office, 1968, pp 867–878
15. Kety SS: The biogenic amines in the central nervous system: their possible roles in arousal, emotion, and learning, in The Neurosciences. Edited by Schmitt FO. New York, Rockefeller University Press, 1970, pp 324–336
16. Voith K, Herr F: The effect of various antidepressant drugs upon the tetrabenazine-suppressed conditioned avoidance response in rats. Psychopharmacologia 20:253–265, 1971
17. Marsh GG, Markham CM, Treciokas L: Parkinsonian patients' self-reports of levodopa effects on cognitive and memory changes. Psychosomatics 12:114–116, 1971
18. Loranger AW, Goodell H, Lee JE: Levodopa treatment of Parkinson's syndrome. Arch Gen Psychiatry 26:163–168, 1972
19. Meier MJ, Martin WE: Intellectual changes associated with levodopa therapy. JAMA 213:465–466, 1970
20. Beardslee JV, Puletti F: Personality (MMPI) and cognitive (WAIS) changes after levodopa treatment. Arch Neurol 25:145–150, 1971
21. Kety SS: The possible role of the adrenergic systems of the cortex in learning. Res Publ Assoc Res Nerv Ment Dis 50:376–389, 1972
22. Murphy DL: L-DOPA, behavioral activation, and psychopathology. Res Publ Assoc Res Nerv Ment Dis 50:472–493, 1972
23. Weingartner H: Verbal information retention in alcoholics. Q J Stud Alcohol 32:293–303, 1971
24. Mandler G: Organization and memory, in The Psychology of Learning and Motivation, vol 1. Edited by Spence KW, Spence KT. New York, Academic Press, 1967, pp 327–372
25. Atkinson RC, Shiffrin RW: Human memory: a proposed system and its control processes, in The Psychology of Learning and Motivation, vol 2. Edited by Spence KW, Spence KT. New York, Academic Press, 1968, pp 89–195
26. Weingartner H: Descriminability of free associations. J Clin Psychol 27:254–257, 1971
27. Palermo DS, Jenkins JJ: Word Association Norms. Minneapolis, University of Minnesota Press, 1964
28. Bunney WE Jr, Hamburg DA: Methods for reliable longitudinal observation of behavior. Arch Gen Psychiatry 9:280–294, 1963
29. Murphy DL, Brodie HKH, Goodwin FK, et al: Regular induction of hypomania by L-DOPA in "bipolar" manic-depressive patients. Nature 229:135–136, 1971
30. O'Brian JP, Weingartner H: Associative structure in chronic schizophrenia. Arch Gen Psychiatry 22:136–142, 1970
31. Sommer R, Dewar R, Osmond H: Is there a schizophrenic language? Arch Gen Psychiatry 3:665–673, 1960
32. Shakow D: Psychological deficit in schizophrenia. Behav Sci 8:275–305, 1963
33. Fuller GD, Kates SL: Word association repertoires of schizophrenics and normals. J Consult Clin Psychol 33:497–500, 1969
34. Goodwin FK, Murphy DL, Brodie HKH, et al: L-DOPA, catecholamines, and behavior: a clinical and biochemical study in de-

pressed patients. Biol Psychiatry 2:341–366, 1970
35. Murphy DL, Baker M, Goodwin FK, et al: Behavioral and metabolic effects of L-tryptophan in unipolar depressed patients, in Serotonin and Behavior. Edited by Barchus J, Usdin E. New York, Academic Press (in press)
36. Braddeley AD, Patterson K: The relation between long-term and short-term memory. Br Med Bull 27:237–242, 1971
37. Deese J: The Structure of Associations in Language and Thought. Baltimore, Johns Hopkins University Press, 1965
38. Stewart J, Krebs WH, Kaczender E: State-dependent learning produced with steroids. Nature 216:1223–1224, 1967
39. Overton DA: State-dependent learning produced by depressant and atropine-like drugs. Psychopharmacologia 10:6–31, 1966
40. Goodwin DW, Powell B, Brenner D: Alcohol and recall: state-dependent effects in man. Science 163:1358–1360, 1969
41. Eisdorfer C, Nowlin J, Wilkie F: Improvement of learning in the aged by modification of autonomic nervous system activity. Science 18:1327–1329, 1970
42. Beigel A, Murphy DL: Unipolar and bipolar affective illness: differences in clinical characteristics accompanying depression. Arch Gen Psychiatry 24:215–220, 1971
43. Donnelly EF, Murphy DL: Primary affective disorder: MMPI differences between unipolar and bipolar depressed subjects. J Clin Psychol (in press)
44. Malmo RB: Measurement of drive: an unsolved problem in psychology, in The Nebraska Symposium on Motivation. Edited by Jones MR. Lincoln, University of Nebraska Press, 1958, pp 229–265
45. Duffy E: Activation and Behavior. New York, John Wiley & Sons, 1962
46. Takagi H, Satoh M, Yamatsu K, et al: Central effects of 3,4-dihydroxyphenylalanine and 5-hydroxytryptophane on tetrabenazine-pretreated rabbits with special reference to the possible role of catecholamine and serotonin on the brain. International Journal of Neuropharmacology 7:265–273, 1968
47. McKean CM, Schanberg SM, Giarman NJ: Amidoacidemias: effect on major performance and cerebral serotonin. Science 157:213–215, 1967

DISCUSSION

RICHARD ABRAMS, M.D. (New York, N.Y.)—Dr. Henry and his associates have presented a wealth of fascinating data on the interaction of mood, memory, and biogenic amines in man. Their work raises many interesting questions, but for reasons of space, I wish to consider only two main points: the relationship between memory and clinical state and the conceptual model used to explain it.

The authors have demonstrated impairments in serial learning and free recall in depressed and manic patients. Immediate recall was unimpaired, suggesting adequate perception and attention, and the authors correctly conclude that the observed failure in memory occurred during the transfer of information from short- to long-term storage. However, they also report that administration of L-dopa or L-tryptophan to depressed patients resulted in improvements in verbal learning without any change in clinical state. This finding requires confirmation, because it implies that there is a dissociation between mood and memory produced by the administration of amine precursors that is not present in changes in clinical state occurring without these compounds. One might have expected that memory functioning would worsen in depressed patients receiving L-tryptophan, on the basis of Essman's finding of impaired learning in mice after parenteral administration of serotonin increased the cerebral concentration of this amine (1).

The authors used paired t tests to discern differences in mean depression ratings for the placebo and active drug groups and failed to find a therapeutic effect for L-dopa or L-tryptophan. It might be useful to ask whether there is a significant relationship between changes in the depression ratings and changes in the memory scores for patients receiving the drugs, rather than to accept the possibly unrelated statements that the precursors improve memory function and are not antidepressants. It also remains possible that depression was alleviated by L-dopa and L-tryptophan, but that this improvement was not detectable with the measure of clinical change these investigators employed. The 24-item Bunney-Hamburg nurses' rating scale they used contains a subgroup of items reflecting depression, but does not measure psychomotor retardation, insomnia, or anorexia and weight loss. Improvement in these symptoms might have occurred without a change in depression rating. The authors note that several of their depressed patients did show psychomotor retardation and, indeed, the improvement in their learning performance after treatment with L-dopa is attributed to a possible improvement of this symptom. Insomnia might also have improved, because it has been shown that both L-tryptophan and phenylalanine increase rapid eye movement (REM) and slow-wave sleep in man (2). I urge further study of this possibility and suggest that the psychiatrist-administered Hamilton Rating Scale for Depression may be a more valid scale for changes in the depressive state.

The second point I would like to discuss is the model the authors used to explain the findings. The authors propose an "inverted-U function for arousal." This is a "bipolar" model, with mania and depression at opposite poles and normality in the middle. Court (3, 4) has reviewed the evidence for this model and found it insufficient; he has proposed instead that the observed relationships are better thought of as a "continuum" of which normality is one pole and in which mania is a more severe departure than depression. He presents a number of arguments in favor of this view, including some observations that depressed patients are in a state of increased, not decreased, arousal. The insomnia and increased cortisol secretion of depressed patients support this concept. Whybrow and Mendels (5) have also suggested that depression is a state of high arousal, characterized by a reduction in REM and slow-wave sleep, an increase in muscle tension on the resting electromyogram, and a prolongation of EEG alpha blocking. In the present study, the errors of omission by depressed patients and those of commission by manic patients can readily be interpreted as a progression in severity of impairment from depression to mania.

Since the authors do not report the administration of biogenic amine precursors to manic patients, there is no basis in their study for choosing between conceptual models. I would, therefore, suggest a trial of L-dopa or L-tryptophan in manic patients. If memory or clinical state improve, the continuum hypothesis is supported; if they do not, the "bipolar" hypothesis will be favored, along with the "inverted-U function for arousal" proposed by the authors.

REFERENCES

1. Essman W: The role of biogenic amines in memory consolidation, in Biology of Memory. Edited by Adam G. New York, Plenum Press, 1971, pp 213–238
2. Williams HL: The new biology of sleep. J Psychiatr Res 8:445–478, 1971
3. Court JH: Manic-depressive psychosis: an alternative conceptual model. Br J Psychiatry 114:1523–1530, 1968
4. Court JH: The continuum model as a resolution of paradoxes in manic-depressive psychosis. Br J Psychiatry 120:133–142, 1972
5. Whybrow PC, Mendels J: Toward a biology of depression: some suggestions from neurophysiology. Am J Psychiatry 125:1491–1500, 1969

The Diagnostic Decision-Making Process: Factors Influencing Diagnosis and Changes in Diagnosis

BY DAVID J. FITZGIBBONS, PH.D., AND DEAN T. HOKANSON, PH.D.

In their study of four groups of patients diagnosed as either psychotic or nonpsychotic, the authors found that disturbed ideation and disordered speech content were the two most important diagnostic considerations and that in the absence of such widely used indicators of differential diagnosis, prognostic inferences were given undue weight. They suggest that when a patient's diagnostic status is ambiguous, special attention should be given to clinical observations of such categories as forms of speech, motor activity, and object relations instead of to subjective impressions, which tend to be misleading.

THE ISSUE OF PSYCHIATRIC DIAGNOSIS is complex and beset by confusing conceptual difficulties as well as by firmly rooted attitudes and affects that contribute a degree of irrationality to virtually all of the currently popular positions. Zubin's extensive review of the literature (1) attests to the fact that it is not difficult to justifiably criticize both the reliability and the validity of psychiatric diagnosis. Shearn and Whitaker (2) have discussed the difficulties involved in arriving at a research definition of the widely used diagnostic category of schizophrenia. Fitzgibbons and Shearn (3) have shown that at the level of conceptualization, ideas about that same diagnostic category vary significantly with the diagnostician's professional identity, theoretical orientation, and the type of organization in which he practices.

If diagnostic categories are ever to become truly useful in the important functions of description and communication, it is crucial to understand the factors that contribute to the diagnostic decision-making process. Few empirical investigations have directly confronted this issue. Ward and associates (4) claim to have accounted for one-third of the variation in psychiatric diagnosis, attributing it to inconsistencies within the diagnostician. Shepherd and associates (5), in their focus on the psychiatric interview as the crucial step in diagnostic decisions, attribute disagreement to variations occurring at three levels: observation, inference, and the employment of the nosological scheme.

The present study was designed as an attempt to isolate bits of information available to the diagnostician (including his own observations, patients' behavior on the nursing units, and patients' self-reports) that may influence the diagnostic decision and changes in diagnosis from admission to later evaluation. It was decided for this initial study to dichotomize diagnosis into two very gross categories—psychotic and nonpsychotic.

At the time this work was done the authors were with the Institute of Living, 400 Washington St., Hartford, Conn. 06106, where Dr. Fitzgibbons is Research Psychologist and Dr. Hokanson was Intern in Clinical Psychology.

METHOD

A list was drawn from the Institute of Living's automated record-keeping system of all current inpatients, except those with diagnoses of organic disorders, who had been assigned both a provisional diagnosis at admission and a staffing diagnosis three weeks later. The admission diagnosis is usually made by the psychiatrist or psychiatric resident to whom the patient has been assigned for treatment. The staffing diagnosis usually emerges from a conference between the patient's therapist and one or two senior members of the psychiatric staff, although if the therapist is himself a senior staff person he may make this diagnosis without conferring with anyone else.

From this list, four groups of patients were established: those patients whose diagnosis changed from nonpsychotic to psychotic (N = 13); those whose diagnosis changed from psychotic to nonpsychotic (N = 11); a random sample of patients who were diagnosed as psychotic at both evaluations (N = 24); and a random sample of patients who were diagnosed as nonpsychotic at both evaluations (N = 28).

Three sets of scores were derived for each patient: Minnesota Multiphasic Personality Inventory (MMPI) scale scores for the three validity scales, the ten clinical scales, and the ego strength scale; four factor scores from the Institute of Living automated nursing notes (6), constituting measures of anxiety, depression, unacceptable behavior, and adaptive behavior; and a set of 12 scores derived from the Institute of Living automated mental status examination (7). Each of these 12 scores was based on a conceptual category of psychological functioning as rated by the initial diagnostician at the time of admission. A sample of the items that contributed to each of the categories is shown in appendix 1.

A one-way analysis of variance design tested the significance of the differences between group means for each MMPI scale score, each factor score from the nursing notes, and each of the mental status categories. For each significant analysis of variance, Duncan's New Multiple

TABLE 1
Analysis of Variance and Duncan's New Multiple Range Test for the Significance of Differences Between Means of Four Diagnostic Groups on Mental Status Categories

Mental Status Category	Group Means				F	Level of Significance	η^2
	Psychotic	Nonpsychotic to Psychotic	Nonpsychotic	Psychotic to Nonpsychotic			
General behavior positive	.19	.28	.22	.14	1.00	n.s.	–
General behavior negative	.19	.09	.10	.07	2.03	n.s.	–
Disordered motor activity	.10	.07	.04	.02	2.76	$p<.05$	.10
Voice abnormalities	.16	.17	.06	.08	5.57	$p<.005$	.19
Disordered forms of speech	.16	.11	.07	.05	5.11	$p<.005$	.18
Disordered speech content	.24	.13	.12	.11	9.59	$p<.001$	.29
Disturbed ideation	.13	.05	.03	.04	6.03	$p<.001$	.20
Impaired judgment	1.27	1.04	.90	.84	1.55	n.s.	–
Perceptual disorders	.10	.06	.02	.02	4.06	$p<.025$	.15
Disturbed affect	.41	.24	.31	.27	1.99	n.s.	–
Disturbances in object relations	.78	.58	.34	.40	6.44	$p<.001$	.21
Lack of adaptive capacities, insight, and motivation	.85	.52	.52	.63	3.19	$p<.05$	.12

Range Test was used to test the significance of the differences between each possible set of means and eta square (η^2) was computed.[1]

The three sets of scores studied represent three different types of observation that could, with some plausibility, be useful in arriving at a diagnostic decision: patients' self-reports at the time of admission, systematic and standardized observations by the diagnostician at the time of admission, and standardized observations of behavior by the nursing staff during the first three weeks of hospitalization.

RESULTS

None of the MMPI scale scores and none of the nursing note factor scores significantly discriminated among the groups. It thus appears that neither a set of standardized self-report items administered at admission nor discrete descriptions of the patients' behavior during the first three weeks of hospitalization contributed significantly to the decision made about diagnosis.

As table 1 shows, the mental status examination appears to have been the crucial factor in the diagnostic decisions.

It is clear that the two no-change groups are psychiatrically very different. The means of these two groups differ significantly from each other on eight of the 12 mental status categories, failing to differ on only general behavior positive, general behavior negative, impaired judgment, and disturbed affect. In each of the eight significant categories more pathology is attributed to the psychotic group than to the nonpsychotic group. The greatest difference is in the category of disordered speech content. Observations of pathological speech content accounted for almost 30 percent of the variance in the diagnostic decisions ($\eta^2 = .29$). Other issues that contributed heavily to the diagnostic decision were judgments about disturbances in object relations ($\eta^2 = .21$), disturbed ideation ($\eta^2 = .20$), voice abnormalities ($\eta^2 = .19$), and disordered forms of speech ($\eta^2 = .18$). Also contributing to the diagnostic decision, but at a somewhat lower level, were judgments about perceptual disorders ($\eta^2 = .15$), adaptive capacities ($\eta^2 = .12$), and disordered motor activity ($\eta^2 = .10$). It is clear that a large number of traditional psychiatric symptoms were present to a larger degree in the psychotic group than in the nonpsychotic group, resulting in little if any ambiguity and rendering the diagnostic decision rather straightforward.

It was originally presumed that the two "change" groups consisted of patients who posed diagnostic problems. Although there was no direct evidence to support this assumption, it was possible to investigate an indirect index of diagnostic difficulty: referral for psychological evaluation. Over the past five years the rate of referral of inpatients for psychological testing has been about 40 percent. For the no-change groups the referral rate was 43 percent, while for the change groups the rate was 75 percent, a figure far in excess of the expected 40 percent ($p = <.001$). This is indirect evidence in support of the assumption that the change groups posed special diagnostic problems.

Examination of the mean scores of the group that was originally diagnosed as nonpsychotic but later as psy-

[1] Because of the way the extraction program was written the scores for the mental status categories are not means of the patients' total score but means of their mean score. For example, the category "general behavior positive" has 17 items. If a patient were given a total score of 10 on these 17 items, his score used in the analysis of variance would be $\frac{10}{17}$ or .588. The η^2 coefficient, or the correlation ratio of η^2, is the proportion of the total sum of squares of the dependent variable (Y), which is associated with independent variable (X) group membership, hence the between-group sum of squares. Any source of variance that yields an F ratio can also yield an index of how much relationship there is between this source and the dependent variable (8).

chotic (table 1) shows that this group is more similar to the psychotic group than is either of the other two.[2] They do not differ in judgments about pathology in the areas of voice, motor activity, forms of speech, perception, and object relations. Since the two groups demonstrate the same degree of pathology in these categories, what are the issues that contribute to the diagnostic problem? As can be seen in table 1, problems in diagnosis can in large measure be attributed to two categories—disordered speech content and disturbed ideation—the two categories that account for the largest proportion of variance in the diagnostic decision. While the nonpsychotic to psychotic group was observed to have less pathology in speech content and ideation than the psychotic group, it did not differ in these areas from either the nonpsychotic group or the psychotic to nonpsychotic group. When this result is considered together with similarities between this group and the psychotic group, the result is a confusing state of diagnostic ambiguity. The two groups share many of the same areas of pathology but differ significantly in the two areas that contribute most to the diagnostic dichotomy, i.e., psychotic versus nonpsychotic.

As can also be seen in table 1, the group of patients who changed from psychotic to nonpsychotic are very similar to the nonpsychotic group, differing in only two categories—disturbances in object relations and lack of adaptive capacities, insight, and motivation. In the category of disturbances in object relations the mean score of these patients differs significantly from that of both the psychotic group and the nonpsychotic group but not from that of the other change group (those who changed from nonpsychotic). Thus although judgments and observations about the quality of a patient's object relations provide useful diagnostic cues when other diagnostic indicators are unambiguously present, they are of little help when other more powerful diagnostic indicators are absent.

Although it seems rather clear from the data that the change groups posed diagnostic problems because neither differed from the nonpsychotic group on the two most powerful indicators of psychosis—disordered speech content and disturbed ideation—the question arises as to why one was, on first impression, called nonpsychotic despite its considerable similarity with the psychotic group and why the other was initially called psychotic despite its similarity with the nonpsychotic group. The only result from this study bearing on that question is that the group whose diagnosis changed from psychotic to nonpsychotic was judged to be not significantly different from the psychotic group in the areas of adaptive capacities, insight, and motivation, while the two other groups were different. Of all mental status categories this one bears most closely on the issue of prognosis and is in a sense the most judgmental, requiring inferences beyond direct observations.

[2] A copy of the results of the multiple comparisons in tabular form is available from Dr. Fitzgibbons on request.

The results from a number of categories—disordered motor activity, voice abnormalities, disordered forms of speech, and perceptual disorders—suggest that at the time of the initial diagnosis, the greater pathology of the group eventually to be called psychotic was already apparent. In addition, the group that would finally be called nonpsychotic was clearly closer to the nonpsychotic group than to any other group on variables such as voice abnormalities, forms of speech, and perceptual disorders. The data point to the inference that at the time of the initial diagnostic decision (at admission) for patients comprising the two diagnostically difficult groups, undue weight may have been given to more judgmental prognostic inferences at the expense of more traditional psychiatric observations. At the time of the second diagnostic decision (three weeks after admission) more weight was given to data that were already initially available, while the observations that lead to inferences about adaptive capacities, insight, and motivation were seen within the context of the patient's entire ego functioning.

DISCUSSION

The significant results from the analysis of the mental status examination may be usefully applied to an understanding of the diagnostic process. In a sense, they provide an empirically derived operational definition of psychosis (more specifically, schizophrenia, since all psychotic subjects were diagnosed as schizophrenic). In addition, the results help to pinpoint issues that lead to diagnostic problems.

It appears that observations or reports of ideational abnormalities and disordered speech content are the two most important considerations used in deciding if a patient should be called psychotic or nonpsychotic. Other areas given important consideration are forms of speech, perception, voice, and motor activity. This is consistent with Cancro's recent suggestion (9) that the one critical criterion for the diagnosis of schizophrenia should be a demonstrable thought disorder, for it is through observations of a person's speech, ideation, and perceptual processes that we make inferences about the quality of his thought. There is some evidence to suggest, however, that in practice the term "thought disorder" may be unduly limited to speech content and ideation, with less consideration given to the formal aspects of speech, perception, and voice quality.

It is suggested from the data that in the absence of widely used indicators of differential diagnosis (primarily ideational disorders and disordered speech content), prognostic inferences are given undue weight to the extent that a diagnostic label that is later seen to be in error is applied to the patient. Perhaps an awareness of this tendency could be useful in reducing initial diagnostic errors. The results from this study suggest that when a patient's diagnostic status is ambiguous because of the therapist's inability to demonstrate by either observation or history important signs and symptoms such as disordered ideation and abnormal speech content, the thera-

pist should give special attention to other categories while consciously inhibiting the influence of more subjective impressions. Increased attention should be given to forms of speech (as opposed to content), motor activity, voice, and object relations. Disturbances in these areas are communicated in a more subtle manner, and often their detection requires a high degree of clinical awareness. This is especially true of disordered formal speech, which can occur within the context of well-ordered content.

An additional point to be emphasized is the suggestion that prognostic inferences are originally given more weight in the diagnostic process than less inferential clinical observations. Implicit in the Kraepelinian-Bleulerian system, which continues to influence psychiatric classification, is the notion that schizophrenia has a poorer prognosis than other disorders. Allegiance to this point of view has been shown to be endorsed by diagnosticians at the level of description (3), and evidence from this study suggests that it also influences practice. It would appear that at the point of initial diagnosis, prognostic judgments are given more consideration than descriptive observations, at least in cases where several observations are inconsistent with each other.

REFERENCES

1. Zubin J: Classification of the behavior disorders. Annu Rev Psychol 18:373–406, 1967
2. Shearn CR, Whitaker LC: Selecting subjects in studies of schizophrenia. Schizophrenia 1:4–8, 1969
3. Fitzgibbons DJ, Shearn CR: Concepts of schizophrenia among mental health professionals. J Consult Clin Psychol 38:288–295, 1972
4. Ward CH, Beck AT, Mendelson M, et al: The psychiatric nomenclature: reasons for diagnostic disagreements. Arch Gen Psychiatry 7:198–205, 1962
5. Shepherd M, Brooke EM, Cooper IE, et al: An experimental approach to psychiatric diagnosis: an international study. Acta Psychiatr Scand 44 (suppl 201), 1968
6. Rosenberg M, Glueck BC, Stroebel CF, et al: Comparison of automated nursing notes as recorded by psychiatrists and nursing service personnel. Nurs Res 18:350–357, 1969
7. Donnelly J, Rosenberg M, Fleeson WP: The evolution of the mental status—past and future. Am J Psychiatry 126:997–1002, 1970
8. Cohen J: Some statistical issues in psychological research, in Handbook of Clinical Psychology. Edited by Wolman B. New York, McGraw-Hill, 1965, pp 95–121
9. Cancro R: A classificatory principle in schizophrenia. Am J Psychiatry 126:1655–1659, 1970

APPENDIX 1

Sample Items from the Mental Status Categories

GENERAL BEHAVIOR POSITIVE (N = 17)
- Cooperative
- Sincere
- Dependable

GENERAL BEHAVIOR NEGATIVE (N = 49)
- Evasive
- Demanding
- Asocial

DISORDERED MOTOR ACTIVITY (N = 35)
- Awkward
- Overactive
- Pacing

VOICE ABNORMALITIES (N = 11)
- Whining
- Quavering
- Whispering

DISORDERED FORMS OF SPEECH (N = 27)
- Unusual syntax
- Excessive speech
- Imprecise

DISORDERED SPEECH CONTENT (N = 36)
- Illogical
- Disorganized
- Bizarre associations

DISTURBED IDEATION (N = 34)
- Preoccupied with suicidal ideation
- Delusions of grandeur
- Ideas of reference

IMPAIRED JUDGMENT (N = 4)
- Impaired in social relations
- Impaired in family relations
- Impaired in sexual relations
- Impaired in financial matters

PERCEPTUAL DISORDERS (N = 24)
- Depersonalization
- Déjà vu
- Time appears to pass slowly

DISTURBED AFFECT (N = 22)
- Ambivalent
- Anxious
- Hopeless

DISTURBANCES IN OBJECT RELATIONS (N = 5)
- Restricted
- Transitory
- Dependent on

LACK OF ADAPTIVE CAPACITIES, INSIGHT, AND MOTIVATION (N = 11)
- Adjustment potential limited by lack of pleasurable experiences
- Poor insight into illness
- Not motivated for treatment

Engaging Heroin Addicts in Treatment

BY JOHN A. RENNER, M.D., AND MARK L. RUBIN

The authors suggest that an unselected group of addicts can be engaged in treatment and that a successful outpatient methadone detoxification program can be carried out in a general hospital psychiatric emergency clinic. However, it requires a structured program, interested and trained staff members who are available on a daily basis (including some paraprofessionals), and a responsible senior staff member who can run the program, set necessary limits, and provide support for the other staff members. Such a program must be seen as only the beginning of a long-term therapeutic effort for addicts and is clearly most successful with addicts who can be reached at an early stage in their addiction.

OPIATE DEPENDENCY is a chronic disorder characterized by relapses and recurrent treatment failures. Detoxification and drug-free treatment approaches have been criticized because of their lack of appeal to many addicts, their high dropout rates, particularly in the early stages of treatment, and their insistence on a high level of patient motivation. These problems have contributed to the attractiveness of methadone maintenance as a treatment method. The paucity of studies with adequate controls has made it difficult to compare the relative effectiveness of different treatment approaches. This problem is further complicated by an absence of data on the majority of addicts who are not in any treatment program. Some observers have reported that less than 40 percent of the total addict population is motivated to participate in any form of treatment, including methadone maintenance (1). How this supposedly unmotivated group can be successfully engaged in treatment is one of the major questions facing drug programs today.

One of the few places where treatment staff have contact with this patient population is the emergency psychiatric clinic of large metropolitan hospitals. This paper reports on the success of our experience during a 12-month period with an outpatient methadone detoxification program at the Massachusetts General Hospital. Our findings are in marked contrast to those in an earlier article reporting on 206 heroin users who sought treatment in this same clinical setting (2). The earlier study reported no evidence of improvement for any of the patients during an 18-month period. The addicts had been offered a choice of various treatments, including psychotropic drugs, individual counseling, group psychotherapy, and outpatient methadone detoxification. The authors commented on their failure to engage young heroin abusers therapeutically using traditional outpatient therapies, with or without methadone detoxification, and concluded that such treatment methods were without merit. This conclusion was supported by their finding that less than three percent of their patients followed the recommendations that they return for even one outpatient visit.

These findings could easily be interpreted to suggest that such patients are unmotivated and untreatable, or that detoxification is an unproductive treatment approach. This is reminiscent of medicine's long-standing reluctance to treat alcoholics and the tendency to blame treatment failure on the patient rather than on the treatment method. Chafetz convincingly demonstrated that an allegedly unmotivated group of chronic alcoholics could be engaged in outpatient treatment if appropriate changes were made in the clinic's approach to these patients (3).

In response to our previous failure with heroin addicts, and guided by Chafetz' success with alcoholics, the psychiatric clinic at the Massachusetts General Hospital completely revised its approach to these patients. The patients' response to the new treatment program was very good and suggested that this clinical setting can play a useful role in the treatment of heroin users and that a significant number of such unselected patients can be effectively engaged in treatment.

METHOD

Setting

The treatment program was carried out in the walk-in psychiatric clinic at the Massachusetts General Hospital. This is a 24-hour emergency psychiatric clinic where patients are seen without appointment. The operation of this clinic has been described in detail by Lazare and Eisenberg (4). During the 12-month period of this study, 25 first-year residents rotated through the clinic.

A major change in the operation of the clinic was the availability of ten "street workers." These were young paraprofessionals who had little or no formal psychiatric training and were similar in age to the addicts. Only one of the paraprofessionals was a former addict, though several had used drugs. These street workers tended to be less authoritarian than the psychiatric residents and were

Dr. Renner is Instructor, Department of Psychiatry, Harvard Medical School, Massachusetts General Hospital, Fruit St., Boston, Mass. 02114. Mr. Rubin is an undergraduate at Harvard University and at the time of this study was a street worker at Massachusetts General Hospital.

more readily available for individual counseling. It was easier for a patient to come to rely on his street worker, who was constantly available, than to rely on the residents, who worked in the clinic on a rotating basis. Because the paraprofessionals were not involved in the demanding work schedule of psychiatric residents, they were able to give their full attention to the addicts. In addition, one full-time member of the psychiatric staff with a special interest in addiction became available for supervision of the residents and street workers and for general coordination of the clinic's program for heroin users.

Treatment Program

The clinic set up a carefully structured program for outpatient methadone detoxification and offered this to all patients. The clinic did not offer methadone maintenance; a patient requesting this method of treatment was referred elsewhere. Patients were not offered other more traditional forms of outpatient psychiatric treatment unless they specifically requested it.

An important aspect of the treatment approach involved explaining to the patient that the definitive treatment of drug abuse required a long-term commitment to a treatment program (outpatient or residential), and that our methadone detoxification program was only the first step. During the course of our involvement with patients undergoing detoxification, we stressed their need to explore the various long-term treatment programs available and to select the program best suited to their needs.

All new clinic patients were first seen by a psychiatric resident, who obtained a psychiatric history and performed a physical examination to detect signs of drug abuse and signs of withdrawal. A urine sample was obtained and screened for quinine, opiates, barbiturates, and amphetamines. The patients were then interviewed by a street worker, who obtained a detailed history of drug use, explained the operation of the program, and offered assistance with other problems (referral for social work assistance, help in finding a place to live, etc.). If we could not document clear physiological signs of opiate withdrawal, the patient was instructed to return to the clinic when he or she was in withdrawal.

Once withdrawal could be verified by physical examination, the patient was given 10 to 40 mg. of methadone each day, administered orally in divided doses in the clinic. The patients were required to return to the clinic twice a day at specified times, seven days a week. Under no circumstances were patients given prescriptions, pills, or liquid methadone to take with them. Methadone was gradually reduced over a period lasting from three to 20 days, depending on the size of the patient's habit and the length of time he had been addicted. Most addicts could be detoxified within ten days.

During the initial weeks of the new program, each addict was required to see a street worker daily for individual counseling. This proved difficult to implement because of staff working schedules and was replaced with mandatory daily attendance at a group run by two street workers. Group treatment proved highly successful and helped the addicts overcome their fear of the traditional medical setting. In the group, patients were able to develop trusting relationships with their peers, both other patients and street workers. Emphasis in the group was on rehabilitation plans such as finding a job, entering long-term residential or outpatient programs, and the discussion of other common problems. The groups were supportive in nature and there was a minimum of confrontation. Patients were also seen for individual counseling, but only if they requested it. Attendance at the group and participation in detoxification was limited to eight individuals at any one time. Other patients were placed on a waiting list during the few weeks in which we had large numbers requesting detoxification.

The program operated with a clear set of regulations, copies of which were signed by all patients when they began treatment. Violation of any regulation (e.g., missed appointments, use of other drugs, disruptive behavior) led to a patient's being placed on "probation" and the requirement that he spend more time in counseling sessions or in other treatment activities. Repeated violations led to dismissal from the program, with the proviso that a patient could return if he first became involved in a full-time day-care program. As our experience in working with addicts increased, the organization of the program became progressively more structured, i.e., the number of regulations increased and they became more explicit. While this tended to increase the patients' initial complaints, it also reduced their disruptive behavior.

Data Collection

The study was conducted prospectively over 12 months, from January to December 1971. A special form was filled out for each heroin abuser who came to the clinic. Each subsequent visit was recorded and the forms were collected when the patient ceased to attend the clinic. All patients were included in the study, regardless of age, as long as they identified themselves as heroin users and stated that they wished treatment. The data collected included age, sex, length of addiction, type and quantity of drugs used, marital status, employment, and place of residence. This paper concerns itself solely with results observed while the patients were seen at the clinic. Treatment was considered successful if the patient was willing to return to the clinic and to complete the detoxification program.

NATURE OF POPULATION

A total of 456 patients were seen during the 12-month period. There were 310 men (68 percent) and 146 women (32 percent). They ranged in age from 15 to 47, with a mean age of 22. Seventy-seven percent were single, 20 percent were married, and three percent were divorced (see table 1).

The average patient was a young, single, white man from a middle-class or working-class background, with a relatively short history of addiction. Our patients seemed to be a clearly separate group from the traditional addict (black ghetto resident with a large, long-term habit) and

TABLE 1
Demographic Data: Comparison Between Present Study and Previous Study

Item	Present Study 12 Months (1971) (N=456)		Previous Study 18 Months (1969–70) (N=206)	
	Number	Percent	Number	Percent
Sex				
Men	310	68	167	81
Women	146	32	39	19
Marital status				
Single	353	77	154	75
Married	91	20	38	18
Divorced	12	3	14	7
Employment status				
Students	8	2	Not available	
Employed	55	12	Not available	
Unemployed	393	86	Not available	

from the middle-class social dropouts described in work done with drug abusers in Haight-Ashbury (5). Many of our patients still lived with their families. Those who could be described as "alienated" were primarily alienated as a result of their drug use and the antisocial behavior necessary to support a drug habit. There was a striking absence of the sociopolitical rhetoric and mores associated with middle-class dropouts. Our patients typically presented a history of long-standing personal maladjustment, with school problems, juvenile delinquency, and other evidence of psychopathology that antedated their drug use. In general, we have been seeing a "working-class junkie" who is the product of white inner-city ethnic neighborhoods and the less affluent suburbs.

RESULTS

The average number of patients seen per month climbed more than threefold, from 11 to 38, in less than a one-year period. Many new patients were referred by former patients. This indicated our success in gaining the trust of this often distrustful group.

Compared with the previous study, there was no significant difference in the age or marital status of the patients seen during the period of this study. The broader age range reflects the inclusion in this study of data on nine older addicts who attended the clinic during this period. Comparative figures on employment were not available.

The major finding in the first study was that most patients (97 percent) failed to return for follow-up visits. This occurred even when such patients were offered methadone detoxification. The results of the current study are strikingly different (see table 2); 76 percent of those recommended for treatment returned for at least a second visit, and 57 percent were judged to have become engaged in the program, as evidenced by three or more clinic visits. All records were reviewed to determine the number of patients who successfully completed detoxification (continued attendance at the clinic until their methadone dose was reduced to 5 mg. a day). One hundred eighteen patients completed detoxification (24 percent of the total group and 27 percent of the group recommended to return for treatment); each successful patient attended for an average of 12 visits.

If we eliminate from the study those who made fewer than three visits to the clinic and focus on the remaining 247 patients, 48 percent completed detoxification. This indicates that once patients can be engaged in treatment, a large number will be able to complete the program. It was the impression of the staff that many of those making only one or two visits were "clinic shopping," were often trying to get extra doses of methadone, and were not seriously interested in detoxification or any other type of treatment.

Completion of detoxification was clearly related to the length of time an individual had been using heroin and to the size of his daily habit. The shorter the time and the smaller the habit, the greater the chance of successful treatment (see figure 1).

In terms of length of time using heroin, the proportion of patients successfully detoxified dropped from a high of

TABLE 2
Treatment Results for Patients Asked to Return to Clinic (N=456)

Category	Number	Percentage of Total Group	Percentage of Group Recommended to Return
Recommended to return	436	96	
Returned for treatment	330	72	76
Engaged in treatment (3 or more visits)	247	54	57
Completed detoxification	118	24	27

FIGURE 1
Proportion of Patients Completing Detoxification According to Length of Time Using Opiates

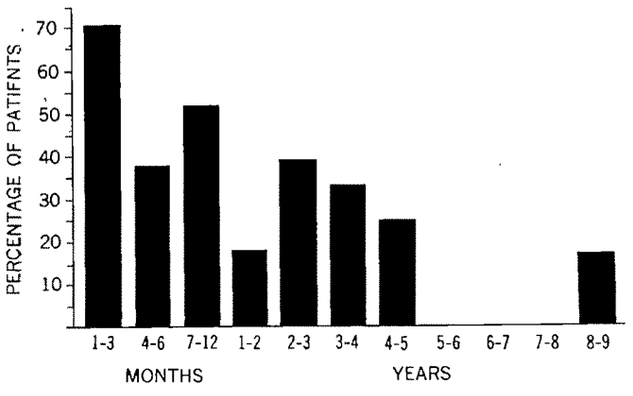
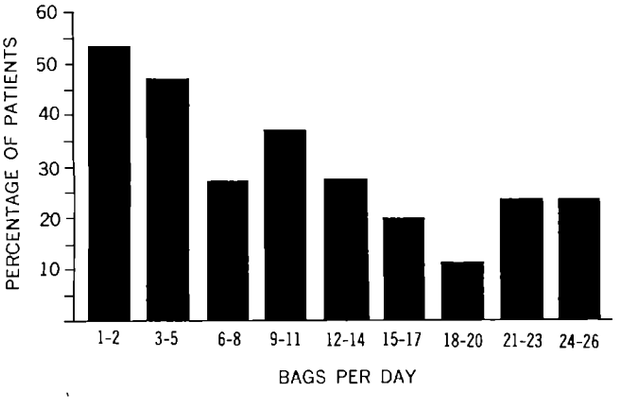


FIGURE 2
Proportion of Patients Completing Detoxification According to Daily Consumption of Opiates



71 percent for those using it for three months or less to 25 percent for those using it for five years or more. A similar finding was made for the amount of heroin used daily. Of those reporting the use of one or two bags a day, 54 percent were detoxified. This gradually dropped to 23 percent of those claiming to use 21 or more bags a day (see figure 2).

To further delineate the characteristics of the patients completing detoxification, we compared them across several variables with those who did not complete the program (see table 3).

Age and sex had no significant effect on the patient's chance for successful completion of detoxification. However, these findings suggest that married persons and persons who are still employed did better than average in the program. The small number of divorced persons makes it difficult to interpret the results in this group.

The results of the present detoxification program compare favorably with the results of treatment programs offered to nonaddict patients in our clinic (2). Among a control group of nonaddict patients (described in the previous paper) who were instructed to return to the clinic for treatment, 79 percent returned at least once and 21 percent never returned. In this study, 76 percent returned at least once, and 24 percent never returned. In the previous study, only three percent of addicts had returned at least once.

DISCUSSION

The findings of this study are clearly at variance with the treatment failures reported by the clinic for the previous year. Our ability to successfully detoxify 24 percent of all addicts requesting treatment suggests that the previous failure lay in the structure of the program and not with any inherent difficulty in the procedure of outpatient methadone detoxification or the addiction process itself. While it is not possible to isolate any one component of the treatment approach as the single factor responsible for our increased success in engaging addicts in therapy, we believe that the following observations reflect the more significant changes in the program.

In the previous study, addicts had outpatient methadone detoxification available to them. However, it was just one of several methods of treatment offered. It is our impression that this variety of treatments only served to confuse the addict and the staff and conveyed a lack of certainty that had a negative therapeutic effect. In addition, if the addict did choose detoxification, the working schedules of the clinic staff were such that the patients rarely saw the same staff member twice. Such a situation could have been interpreted by the patient as a lack of concern on the part of the staff and often led to acting out and patient complaints that no one understood or cared about them.

The detoxification program described in this paper made a major effort to correct these difficulties. Patients were offered a clearly defined and tightly structured program and they were seen regularly by the same staff members. Such programmatic certainty and continuity was necessary to counteract the addicts' fear about their inability to resolve their problems and the general lack of structure in their own lives. The patients' opportunities for destructive manipulation were greatly reduced by having them see the same person each day, and it was easier for them to develop a relationship with a staff member.

Because of the manipulative nature of the patients, it is imperative that the staff be well trained to deal with character disorders and that there be close communication among all staff members. The staff must be fully aware of the mechanics and requirements of the program and there must be one individual who is readily available who has the authority to make the treatment and programmatic decisions that occur frequently, even in a tightly structured program. This individual must also convey a strong sense of optimism to the staff and provide whatever support is needed to handle the inevitable frustration encountered in working with this patient population.

During the period described in the previous study, no such support was available to the residents working in the clinic. While O'Malley and associates (2) commented on the zeal of first-year residents and their lack of negative

TABLE 3
Percentage of Patients in Various Demographic Categories Who Successfully Completed Detoxification

Item	Total Number	Successfully Detoxified (Percent)
Men	310	29
Women	146	31
Single	353	23
Married	91	38
Divorced	12	42
Employed	55	53
Total group	456	24

attitudes about the treatment of addiction, it is our impression that busy first-year residents rarely have the time, persistence, or frustration tolerance necessary to establish a successful treatment relationship with an addict. The residents' schedules in our clinic made it impossible for the same resident to be available on a daily basis. The demands associated with providing emergency care to other patients cannot help but generate hostile feelings toward addicts, who are perceived as being manipulative, demanding, and unmotivated even by a group of relatively liberal, socially concerned psychiatric residents.

Because of our inability to change the psychiatric residents' work schedules, we introduced the street workers into the clinic and gave them the primary responsibility for dealing with the addicts. Not only did this permit more consistent staff contact with patients, but it is our impression that the addicts responded in a more positive fashion to the paraprofessionals than to the clinic physicians. Borenstein, while describing a different treatment setting, documented addicts' preference for assistance from paraprofessionals rather than physicians (6). In describing the results obtained at Reality House, Kaufman also stressed the importance of the paraprofessional former addict in engaging patients in the early phases of treatment and the use of psychiatrists and more traditional methods of individual and group psychotherapy only in the latter phases of the program (7). Our findings would support the impressions of both of these observers. Our street workers' enthusiasm, commitment, and acceptance by the patients more than adequately compensated for their lack of formal psychiatric training.

A major part of any successful addiction treatment program is the amount of time spent dealing with the staff's conscious and unconscious negative feelings about addicts. An additional factor in our increased effectiveness with this patient population was the availability of a senior staff member who was able to give structure to the program, willing to make necessary therapeutic decisions, and willing to support and discuss the problems of other staff members.

This study shows that it is possible to identify the more successful candidates for detoxification. A patient's chance for successful detoxification is markedly greater with a shorter length of time of drug use and a smaller amount of heroin used daily. Success is significantly less likely for individuals using more than six bags a day and using heroin for more than one year. There is no difference in the rate of success when measured in terms of age or sex. These findings clearly point out that we need to reach addicts early in the process of their addiction and to implement treatment as soon as possible.

It is our clinical impression that outpatient detoxification is more successful when carried out more slowly. The longer the patients participated in our program, the more likely they were to complete detoxification and make a successful transfer into a long-term program. As our experience with the program increased, we gradually increased the time of detoxification to a 21-day maximum. In addition, we made active attempts to locate patients who failed to return for scheduled visits. In many cases, a telephone call resulted in a patient's return to treatment and the successful completion of detoxification. The most important point in treatment occurs between the second and third visits. This was when most addicts dropped out of our program. It is our impression that this dropout rate can be reduced if patients are given strong reinforcement and support during their initial clinic visits.

Amid all the controversy about the treatment of addiction, detoxification has been overlooked as a significant treatment approach. While it is clear that detoxification alone is of little long-term value, it does represent an opportunity to work with patients who frequently reject both self-help and methadone maintenance and who may represent the majority of the addict population. It is vitally important that approaches to detoxification be reevaluated to learn how this procedure can be used more effectively to engage addicts in treatment.

REFERENCES

1. McKnelly WV: Is methadone not acceptable to the majority of heroin addicts? in Proceedings of the Fourth National Conference on Methadone Maintenance, San Francisco, Calif, Jan 8–10, 1972. New York, National Association for the Prevention of Addiction to Narcotics, 1972, pp 257–258
2. O'Malley JE, Anderson WH, Lazare A: Failure of outpatient treatment of drug abuse, I: heroin. Am J Psychiatry 128:865–868, 1972
3. Chafetz ME, Blane AT, Abram HS, et al: Establishing treatment relations with alcoholics. J Nerv Ment Dis 134:395–409, 1962
4. Lazare A, Eisenberg L: Psychiatric residency training: an outpatient first-year program. Seminars in Psychiatry 2:201–210, 1970
5. Gay GR, Matzger AD, Bathurst W, et al: Short-term heroin detoxification on an outpatient basis. International Journal of the Addictions 6:241–264, 1971
6. Borenstein D: The relative value of the medical staff versus addicts in the rehabilitation of the drug users in a drug abuse program. Johns Hopkins Medical Journal 129:290–297, 1971
7. Kaufman E: A psychiatrist views an addict self-help program. Am J Psychiatry 128:846–852, 1972

Patterns of Professional Activities of Psychiatrists: A Follow-Up of 100 Psychiatric Residents

BY FLOYD K. GARETZ, M.D., AND RICHARD W. ANDERSON, M.D.

The authors attempted to identify predictors of professional achievement from data that are routinely collected from applicants for psychiatric residency training. The strongest predictors were the subject's rank in his medical school class and his age at the beginning of his training. The authors point out, however, that achievement indices frequently correlate highly with each other and that many factors must be considered in selecting psychiatric residents.

THE SELECTION and training of psychiatric residents is a useful but virtually neglected subject of research. Of the existing publications, many are actually position papers on the nature of psychiatric practice and the character of training programs. Felix (1) has stressed the connection of psychiatry to the rest of medicine and favors training that prepares residents for the practice of community psychiatry. Hendrick (2) discussed the problems of educating the resident in dynamic psychiatry. Hamburg (3) and Reiser (4) reviewed the current status of training for psychiatric residents in research strategies and suggested various ways to improve it.

Since the quality of the residents may be more important in their future achievement than the training we give them, several authors have addressed the problem of selection. Garetz (5) found that the Miller Analogies Test, widely used as a selection instrument, did not predict overall clinical competence during residency but that the MMPI was predictive of the residents' personal problems during their training years. Albee (6) pointed out that there was really no selection process, since residents are largely self-selected except those who apply to a few prestigious training centers. Holt and Luborsky (7) have produced the most definitive and comprehensive study on selection of psychiatric residents in their book *Personality Patterns of Psychiatrists*. The selection and evaluation procedures they describe deal primarily with those personality traits which are commonly believed to be useful in "selecting residents for training in psychoanalytically oriented psychiatry with a heavy emphasis on psychotherapy." Their study failed to describe the attributes of successful general psychiatrists and their limited follow-up period allowed the reader only a brief glimpse of the later performance of the former residents.

Several authors are concerned with the performance and aspirations of the residents during training. Modlin and associates (8) studied the growth of residents on various indices of skill and knowledge and found clear increments of growth at various stages of the training and immediate posttraining periods. Pearlin and Klerman (9) examined career preferences of psychiatric residents and found that a large number intended to go into private practice rather than public careers. Halleck and Woods (10) analyzed factors that produce emotional stress and disturbance in residents.

Since the ultimate test of any selection process or training program is the excellence of the work of its graduates, there is need for more long-term studies of practicing psychiatrists. Kreitman (11) studied attitudes of psychiatrists on therapy, but presented no data about how these clinicians were selected as residents. Pasamanick and Rettig (12) studied the status and work satisfaction of psychiatrists, again without reference to selection criteria.

DESIGN

This paper is a report of research that includes a study of selection data and a long-term follow-up of psychiatrists in practice. The original 116 subjects had been psychiatric residents at the University of Minnesota between 1946 and 1960. One hundred of these answered an initial questionnaire in 1964 and constituted the study pool. We were given access to the original data on which their selection was based. These included sex, medical school, age at beginning of training, class rank in medical school, letters of reference, MMPI scores, and Miller Analogies Test scores. It was impossible to retrieve information on every variable for every subject because of changes or inconsistencies in the selection process that occurred over the years; however, information on the first three items was available in all cases. Class rank was recorded for all graduates of the University of Minnesota Medical School, and Miller Analogies and MMPI scores were available in over 50 percent of the cases. Letters of reference were available for half of the subjects and were critically rated by a single judge.

Additional data were obtained from two questionnaires. The first, mailed in 1964, was addressed to all alumni who began training between 1946 and 1960; it

Dr. Garetz is Associate Professor and Dr. Anderson is Professor of Psychiatry, Department of Psychiatry, University of Minnesota Medical School, Box 393, Mayo Memorial Building, Minneapolis, Minn. 55455.

UNIVERSITY COLLEGE OF MEDICINE LIBRARY U. U.

represents a one- to 15-year follow-up. The second questionnaire, completed in 1971 by the same subjects, provides an eight- to 22-year follow-up. Of the 100 subjects who answered the first questionnaire, 92 completed the second. Of those who did not, two were dead and six could not be located. The 1964 and 1971 questionnaires were identical and included data on the psychiatrist's primary professional activity, consultation activities, public service activities, university affiliation, American Board certification, attainment of advanced degrees, American Psychiatric Association fellowship, psychoanalytic training, published papers, child psychiatry training, and place of practice.

Although it is difficult to judge the quality of any psychiatrist's work, we believe the best criteria are the affirmations of competence extended by generally recognized accrediting agencies. We have assumed that a high degree of excellence and productivity is indicated by APA fellowship, American Board of Psychiatry and Neurology certification, a university faculty appointment (or association with a training program), and publication in recognized journals. In addition, qualified psychiatrists must undergo further selection to secure training in psychoanalysis or child psychiatry or to attain advanced degrees.

Our own experience and review of the literature have led us to conclude that little is known about the relationship between the residency selection process and subsequent accomplishment. We therefore decided not to make a specific hypothesis, but to subject all of the data to analysis by computer. Each variable was compared with all the others; we applied the chi-square test to differences between the categorical variables, attempted to correlate the continuous variables, and used a t test to see whether there were significant differences between the categorical and continuous variables.

DATA AND DISCUSSION

Demography of the Sample

The initial study sample consisted of 100 psychiatrists, of whom 92 were men and eight were women. The mean age of the subjects when they began their psychiatric residency was 29.76 years (range: 23 to 49 years). The mean graduating class rank was the 51.73 percentile (range: eight to 97). The mean Miller Analogies score was the 59.30 percentile (range: one to 97). Fifty-five subjects were graduates of the University of Minnesota Medical School and 45 were graduates of other medical schools.

Table 1 shows the mean pretraining MMPI profile of the initial 57 subjects. An interpretation of the profile follows:

> This mean profile shows validity scores which are indicative of a careful and forthright test-taking attitude on the part of the applicants. They were not overly defensive and made no effort at gross denial of common human frailties. The mean score on the K scale, which reflects that kind of subtle defensiveness found to be associated with social class level and reflecting amount of education, among other variables, is slightly lower than that of applicants to medical school.
>
> The clinical scale mean scores are all well within normal limits. The mean Mf score for the male sample is somewhat lower than the average for graduate school males and suggests less than the usual amount of general cultural and aesthetic interests typical for such a group. The Mf score for the female sub-sample suggests a pattern of interests and values very similar to general population females. The highest mean scores, on scales Pd and Ma, reflect the two most common primary elevations in the profiles of young adults from the general population.[1]

TABLE 1
Mean MMPI Profile for Residency Applicants (N = 57)

Scale	Mean T Score
L (Lie)	50.16
F (Frequency)	51.21
K (Correction)	63.97
Hs (Hypochondriasis)	51.21
D (Depression)	51.39
Hy (Hysteria)	55.65
Pd (Psychopathic deviate)	57.42
Mf (Masculinity-femininity)	
Male	60.48
Female	47.67
Pa (Paranoia)	52.44
Pt (Psychasthenia)	53.51
Sc (Schizophrenia)	56.39
Ma (Hypomania)	53.75
Si (Social introversion-extroversion)	43.41
Es (Ego strength)	65.52

Patterns of Achievement of Psychiatrists

To evaluate the achievement and productivity of our sample we used as criteria election to fellowship in the APA, certification by the American Board of Psychiatry and Neurology, university faculty appointment, publication in recognized journals, training in psychoanalysis, training in child psychiatry, and attainment of an advanced academic degree. The data were analyzed comparing the variables with each other. Our report focuses on three relationships: 1) that between preselection data and professional achievement, 2) that between various achievement indicators, and 3) that between achievement indicators and other data.

In our analysis of selection data and later professional achievement, we focused on six factors: the gender of the candidate, the medical school from which he was graduated, his age at the beginning of his psychiatric training, his class rank in medical school, the excellence of his letters of reference, and his Miller Analogies score.

The sex of the subject was to some extent predictive of later professional achievement. Men showed a higher proportion of board certification than women ($p<.01$) By the same token men showed a higher proportion of fellows of the APA, a higher proportion with publica-

[1] The authors are indebted to William Schofield, Ph.D., Professor of Psychiatry and Clinical Psychology, for this interpretation.

tions, and a higher proportion with training in child psychiatry. However, these last three differences did not reach the .05 level of statistical significance. On the other hand, women showed a higher proportion with advanced degrees but this difference did not reach the .05 level of significance.

We studied the relationship of achievement indicators to the medical school from which the candidate graduated. There was no relation.

Class rank in medical school was associated with a greater incidence of all seven achievement indicators. Younger age at the beginning of training was associated with more frequent university appointments ($p<.05$), more frequent publication of papers, and greater incidence of child psychiatry training, psychoanalytic training, and Board certification. A higher Miller Analogies Test score was associated with only two achievement factors: greater incidence of Board certification and greater incidence of APA fellowship. Better letters of reference similarly were associated with only two achievement indicators: greater incidence of Board certification and greater incidence of psychoanalytic training.

Table 2 combines our findings for the predictive value of various selecting data. These data suggest that medical school class rank and the age of the applicant at the beginning of training are our best predictors of long-range professional achievement. The Miller Analogies Test and letters of reference are of questionable value as predictors of later professional achievement.

We wished to determine whether various achievement indicators were related to each other. A number of significant relationships were discovered. Board certification was associated with APA fellowship ($p<.001$); the publication of papers was associated with Board certification ($p<.05$), attainment of an advanced degree ($p<.05$), APA fellowship ($p<.001$), and psychoanalytic training ($p<.05$); university affiliation was associated with APA fellowship ($p<.01$), psychoanalytic training ($p<.02$), and publication of papers ($p<.001$). In general, our data show that achievement in one area was often related to achievement in other areas. The two achievement indicators most consistently correlated with others were publication of papers and university affiliation. However, it is important to point out that university affiliation in our sample was highly influenced by the fact that our graduates were trained in an academic department of psychiatry. It would probably be more accurate to translate university affiliation to mean "teaching" so that our data could be generalized to nonuniversity training programs.

Achievement was related to other patterns of professional activity. Subjects in full-time academic psychiatry more frequently published papers than those in private practice or those who worked in public institutions ($p<.01$). Similarly, full-time academic psychiatrists were more often Board certified than were institutional psychiatrists ($p<.001$), and full-time academic psychiatrists more often had psychoanalytic training than either private practitioners or institutional psychiatrists ($p<.01$).

The established place of practice in 1971 was related to two achievement factors: Board certification was associated with having settled in Minnesota rather than some other place ($p<.05$) and those who did not settle in Minnesota published papers more often than those who did ($p<.02$).

TABLE 2

The Predictive Power of Four Preselection Items for Later Professional Achievement

Achievement Indicators	Medical School Class Rank	Age at Beginning of Psychiatric Training	Miller Analogies Test	Letters of Reference
APA fellowship	$p > .05$		$p > .05$	
Board certification	$p > .05$	$p > .05$	$p > .05$	$p > .05$
University faculty appointment	$p < .05$	$p < .05$		
Publication in journals	$p < .02$	$p > .05$		
Psychoanalytic training	$p > .05$	$p < .05$		$p > .05$
Child psychiatry training	$p > .05$	$p > .05$		
Advanced academic degree	$p > .05$			

Choice of Primary Activity

Primary professional activity is defined in this paper according to the categories in the questionnaire responses. The categories of professional activity chosen for analysis were full-time academic, primarily private practice, and full-time in a public institution. A fourth category, "other," had few responses and was not considered in our analysis.

An analysis of the preselection data revealed that men were in full-time academic work more often than women ($p<.02$), full-time academic psychiatrists had higher class rankings more often than private practitioners or institutional psychiatrists did ($p<.02$), and full-time academic psychiatrists had better letters of reference more often than private practitioners or institutional psychiatrists did ($p<.01$). Data on the medical school from which the subject graduated, the age at which he began his psychiatric training, and his Miller Analogies score were not significantly associated with choice of primary professional activity.

Another variable in our study that was related to the subject's choice of a primary professional activity was that subjects who were in academic work in 1964 left academic work more often than private practitioners or institutional psychiatrists left their respective types of professional activity ($p<.001$).

We conclude that being male and having higher class rank and better letters of reference are predictive of a psychiatrist's going into full-time academic work but that a significant number of those in academic work (50 percent) leave it for some other professional activity within a seven-year period. This is thought to reflect both the difficulty of competing successfully in academia and the lure of greater financial compensation elsewhere.

Final Place of Settlement and Professional Mobility

Final place of settlement is defined in this paper as the subject's place of practice in 1971 (eight to 22 years after completion of residency training). Professional mobility is defined in terms of two factors: a change in place of practice between 1964 and 1971 and a change in primary professional activity between 1964 and 1971.

Selection data were compared with patterns of settlement and mobility. Subjects who were graduated from the University of Minnesota Medical School settled more often in Minnesota (63 percent) than did graduates of other medical schools ($p<.01$) and as of 1971 approximately half the sample had settled in Minnesota. We conclude that in our sample, the medical school from which the subject graduated influenced his settlement in Minnesota more than having taken psychiatric residency in Minnesota did. The subjects' sex, age at the beginning of training, class rank in medical school, letters of reference, and Miller Analogies Test scores were not significantly related to patterns of settlement.

An analysis of mobility patterns revealed that women changed their place of practice ($p<.01$) and their primary professional activity ($p<.01$) more often than men did. The mean medical school class rank was higher for those who changed their place of practice than for those who did not ($p<.05$). The medical school from which the subject graduated, his age at the beginning of training, his letters of reference, and Miller Analogies Test scores were not significantly associated with mobility patterns.

In addition, those in full-time academic psychiatry changed their primary professional activity more often than either private practitioners or institutional psychiatrists did ($p<.01$). Changing one's place of practice was also associated with publishing numerous papers ($p<.05$). Those in full-time academic psychiatry changed their place of practice more often than either private practitioners or institutional psychiatrists ($p<.001$).

The data on mobility are confusing. We believe that these findings represent a complex interaction of several factors. Women are more likely to change their place of practice and their primary professional activity, perhaps because they are apt to make decisions that are based in large measure on family considerations. Academic psychiatrists probably have to move from place to place to advance in rank, while private practitioners and institutional psychiatrists can best achieve their professional goals by staying in one place. We have already mentioned some of the reasons that a high percentage of subjects leave academia.

CONCLUSIONS

Of the six items of information that are available at the time a student is selected for a residency, those with strongest predictive power are the subject's rank in his medical school class and his age at the beginning of his training. Younger applicants, for example, showed higher achievement. Being a man and having a high ranking and good letters of reference were predictors of a career in full-time academic psychiatry. Graduating from the University of Minnesota Medical School was a predictor of setting up a practice in Minnesota. Being a woman and having a high class ranking were predictors for greater professional mobility.

We also found that achievement indicators tended to correlate highly with one another and that university affiliation (or other teaching activity) and the publication of papers were most highly correlated with other achievement indicators. Success in academic psychiatry appeared to require far greater mobility than was necessary in private practice or institutional careers.

Overall we were not impressed with the predictive value of any single selection factor but agree with others who have studied this question that many factors must be considered in selecting psychiatric residents.

REFERENCES

1. Felix RM: The image of the psychiatrist: past, present, and future. Am J Psychiatry 121:318–322, 1964
2. Hendrick I: Psychiatry Education Today. New York, International Universities Press, 1965
3. Hamburg DA: Recent trends in psychiatry research training. Arch Gen Psychiatry 4:215–224, 1961
4. Reiser MF: Research training for psychiatric residents—general problems. Arch Gen Psychiatry 4:237–246, 1961
5. Garetz F: Factors relating to selection of psychiatry residents. J Med Educ 47:145–147, 1972
6. Albee GW: Mental Health Manpower Trends, vol 3. New York, Basic Books, 1959
7. Holt RR, Luborsky L: Personality Patterns of Psychiatrists. Topeka, Menninger Foundation, 1959
8. Modlin HC, Benjamin W, Lacy SB, et al: Growth of psychiatrists during and after residency training. Am J Psychiatry 115:1081–1090, 1959
9. Pearlin LI, Klerman GS: Career preference of psychiatric residents. Psychiatry 29:56–66, 1966
10. Halleck SL, Woods SM: Emotional problems of psychiatric residents. Psychiatry 25:339–346, 1962
11. Kreitman N: Psychiatry orientation: a study of attitudes among psychiatrists. J Ment Sci 108:317–328, 1962
12. Pasamanick B, Rettig S: Status and work satisfaction of psychiatrists in state employ and private practice. Arch Neurol Psychiatry 81:399–402, 1959

Epidemiological Studies of Women Prisoners, I: Medical and Psychiatric Variables Related to Violent Behavior

BY CARLOS E. CLIMENT, M.D., ANN ROLLINS, M.A., FRANK R. ERVIN, M.D., AND ROBERT PLUTCHIK, PH.D.

Ninety-five women prison volunteers participated in an investigation of medical and psychiatric correlates of violent behavior. Violence was measured in five independent ways. Concurrence of all five measures was the criterion for establishing a relationship between violence and a given variable. The variables most highly associated with violence were maternal loss before age ten, severe parental punishment, neurological disorders in relatives, the dyscontrol syndrome, and easy access to weapons. These results underscore the need for a multidisciplinary approach to the study of violence rather than for investigations within isolated disciplines.

THE RELATIONSHIP between biology and violence has been a subject of great interest and a substantial amount of recent research. Many individual variables have been shown to be related to violence. Examples include EEG abnormalities (1–3), epilepsy (4), mental retardation (5), chromosomal abnormalities (6, 7), and neurological abnormalities (8). It was the purpose of this investigation to study the relationship between violent behavior and a broad range of biological and psychiatric variables and to examine the implications of measuring violence by five different methods.

There are a number of reasons for using several measures of violence. The first is that violence is a theoretical term that cannot be measured completely by a single method. For example, violence as measured by a self-evaluation questionnaire reveals a different aspect than that measured by a legal label describing a crime (e.g., assault). Second, the use of multiple measures increases reliability of measurement. A five-item test, for example, is more reliable than a one-item test. Third, agreement among several independent measures of a relationship between violence and some medical variable increases the likelihood that a true relationship exists.

Violence includes a number of different motivational states, such as a disposition to anger, and is also contingent upon many environmental variables, such as the quality of family life and the neighborhood in which the individual lives. The appropriateness of applying this term to a particular case will depend on various types of evidence from which an inference can be made. In view of these points, it is evident that a subject's degree of violence cannot be measured by a single test, judgment, or observation. This implies the need to measure violence in many different ways. In this study, several different measures of violence were used; each inmate was classified as either violent or nonviolent according to each source. The various measures reflect as many aspects of violent behavior as possible and range from the individual's self-evaluation to external behavior judged by others, i.e., by the judicial system, society, or individual correctional officers.

METHOD

The subjects were a group of women prisoners at the Massachusetts Correctional Institution at Framingham (MCIF), which has a capacity of 160. This selection was made for several reasons: the geographic accessibility, the willingness on the part of the staff to cooperate, and the fact that there are no selection criteria for accepting prisoners into the institution other than residence in its catchment area. Because of the quick turnover of inmates at the institution and the possibility of losing subjects, all data were collected in three weeks.

The tests were an electroencephalogram; dermatoglyphic analysis of finger-, palm-, and footprints [1]; the Wechsler Adult Intelligence Scale (WAIS); the Minnesota Multiphasic Personality Inventory (MMPI); the California Achievement Test (CAT); a neurological examination; a gynecological examination; and a psychiatric interview. In addition, a detailed standardized medical questionnaire containing 189 items was used to obtain

Dr. Climent is Assistant Professor, Department of Psychiatry, Universidad del Valle Medical School, Apartado aereo 2188, Cali, Colombia, S.A., and Visiting Lecturer, Department of Behavioral Sciences, Harvard School of Public Health, Boston, Mass. Ms. Rollins is Scientist, Bolt Beranek and Newman, Cambridge, Mass. Dr. Ervin is Professor of Psychiatry, Neuropsychiatric Institute, University of California at Los Angeles. Dr. Plutchik is Director, Program Development and Clinical Research, Department of Psychiatry, Albert Einstein College of Medicine, Bronx, N.Y.

This work was supported by Public Health Service grant MH-19605 from the National Institute of Mental Health and by Law Enforcement Assistance Administration grant NI-72-0230.

The authors wish to thank Ms. Betty Cole Smith, Dr. Ken Bishop, and the staff of the Framingham Institution for Women for their cooperation; Dr Theodore Abelin for his advice in the design of the study; Dr. Terry Andrews, Mr. Ronald Norris, and Dr. Michael Nelson for their participation in the evaluation of the inmates; and the inmates themselves.

[1] The dermatoglyphic analysis was performed by Dr. Lawrence Razavi at Massachusetts General Hospital, Boston.

the histories of medical illness, hospitalizations, diagnoses, and symptoms of the subject and her immediate relatives. Institutional, criminal, and medical records were independently searched for relevant materials.

The questionnaires were given by trained social workers who read and explained the questions to the inmates. To ensure that they were clear, some questions were accompanied by a detailed written description. One question had the following explanation: "Before the age of 10, did you ever have (or were you told that you had) fits, seizures, or convulsions? By seizures we mean shaking of the body, followed by unconsciousness with or without biting the tongue, wetting, and messing."

Measures of Violence

Self. A self-evaluation questionnaire was designed by the authors on the basis of their previous clinical experience. The items all have face validity. Each inmate rated herself on how often she showed certain types of violent behavior. An individual's score was the sum of the frequencies of all questionnaire items. Those prisoners whose scores were above the median were considered violent; those with scores below the median were considered nonviolent.

MMPI Profile. A particular profile described by Davis and Sines (9) as significantly related to hostile and aggressive behavior in men was identified. Inmates who fell within the limits of this profile were labeled violent; those outside the limits were labeled nonviolent.

Correctional Officers. Questionnaires identical to the self-questionnaire mentioned above were filled out by two correctional officers who shared the daytime supervision of the inmates. Each officer was asked to report on the specific aggressive behaviors that she had observed. Each officer's form was scored in the same way as the self-report; the totals were summed for the final score. Those prisoners whose scores were above the median were considered violent; those with scores below the median were considered nonviolent.

Prison. The prison administration prepared a list of crimes they considered violent. Each inmate's entire criminal history (both present and past crimes) was reviewed. A woman was considered violent if she had committed a crime they rated violent; she was considered nonviolent only if she had never committed any violent crime.

Length of Sentence. Length of current sentence was chosen as a measure of the severity of the crime for which the prisoner was currently incarcerated. In some sense it represents society's estimate of the dangerousness of the person, the amount of time she should be punished, or, alternately, the amount of time needed for rehabilitation. The mean sentence at the prison was 5.2 years. Those prisoners whose scores were above the median were considered violent; those with scores below the median were considered nonviolent.

RESULTS

The majority of the prison population belonged to classes IV and V on the Hollingshead scale according to the rating for their usual job (10). Of the 158 inmates, 95 completed all the tests. Twenty-seven refused to cooperate and the others could not be tested for one reason or another.

TABLE 1
Descriptive Characteristics of the Women Prisoners (N=158)

Characteristic	Mean
Age (years)	31.2
Highest grade completed	10.3
Age at first conviction	22.4
Number of crimes	13.2
Length of current sentence (years)	5.2

The general demographic characteristics of the sample of inmates are presented in tables 1 and 2. It is worth noting that there were twice as many white prisoners as black, contrary to what is usually found in prisons for men.

Table 3 shows the distribution of specific diseases or disabilities in the total prison population. It is noteworthy that head injuries and surgery are extremely frequent in this prison population. In addition, major injuries and all kinds of medical illnesses are very frequent in this group.

Dermatoglyphic Patterns

The only dermatoglyphic patterns to be discussed in this paper are the finger patterns and the total finger ridge count. A standard ridge count measure is obtained by adding the individual ridge counts for all the fingers. There were more whorls and arches and fewer ulnars and radial loops in this group than were reported by Holt (11)

TABLE 2
Sociocultural Characteristics of the Women Prisoners (N=158)

Characteristic	Percentage
Religion	
Catholic	46.7
Protestant	38.1
Jewish	0.9
None	10.5
Other	3.8
Race	
White	67.8
Black	30.8
Puerto Rican	0.7
Other	0.7
Marital status	
Single	47.9
Married	18.1
Divorced	13.2
Separated	16.0
Widowed	4.8

TABLE 3
Incidence of Medical Disorders Among the Women Prisoners (N = 158)

Disorder	Percentage
Seizure disorder	13.7
Major central nervous system disease other than seizure	3.6
Headaches	38.6
Heart disease	12.1
Gonorrhea	15.3
Syphilis	3.3
Major infectious diseases	42.3
Minor infectious diseases	59.6
Ear trouble	22.5
Congenital abnormalities	4.6
Tuberculosis	9.0
Asthma	6.9
Allergies	19.7
Head injuries	75.6
Major injuries	30.6
Gynecological surgery	17.0
Surgery other than gynecological	81.6
Delirium	17.0
Fainting from causes other than seizure	16.2
Speech and reading difficulties	8.2

for a control group of British women. The number of arches was more than double that for the British control group, but there was no significant difference in the total finger ridge counts.

Relation Between Violence and Other Variables

To analyze the relation between violence and other variables the following procedure was used. The prisoners were divided into two groups on the basis of any one questionnaire item (e.g., presence or absence of childhood pyromania). We asked what the probability was that any one measure of violence would be greater in one group than in another. The a priori probability is .50 since we have no reason to assume that one of the two abitrarily defined groups is more violent than the other. We also must assume that the five measures of violence are in fact independent (i.e., uncorrelated) measures. Then for any questionnaire item we can calculate the chance probability that all or some of the measures are greater for the group with a given type of history or medical condition.

Using the binomial theorem, the probability that one group is more violent than another on all five violence measures is about three percent. We can then assume that variables for which all the measures of violence favor one of the groups are truly associated with violence.

In this report, associations between variables are considered significant only if there is agreement between all five measures. Since agreement between four of the five measures could occur by chance in 20 percent of the cases, examples of these will be reported only to show trends.

Table 4 shows the correlation coefficients for the five measures of violence. The numbers in the table are the corrected phi coefficients, which produce an approximation to the Pearson product-moment correlation for categorical data (12).[2]

Most of the measures correlate very poorly with one another, as shown by the low coefficients. The highest correlation (.67) is that between the prison administrators' ratings and sentence length. This seems to indicate that these two indices focus on a similar phenomenon, i.e., the prisoner's crime, rather than the administrators' feelings about her aggression or institutional behavior. Most of the measures appear to be independent and focus on different aspects of violence. The assumption of independent measures of violence is therefore reasonably justified.

Variables Correlated with Violence on All Five Measures

Using the above criteria, nine variables were found to be correlated with violence on all five measures (table 5). The variables of medical interest were neurological disorders[3] and other medical disorders in the family (e.g., infections, chronic illness). Nonmedical variables associated with violence were easy access to weapons, the dyscontrol syndrome,[4] loss of one or both parents, homosexuality,[5] and severe parental punishment.

Variables Associated with Nonviolence

The variables consistently associated with nonviolence on all five measures were a clinical diagnosis by a psychiatrist of neurotic depression, a history of psychiatric outpatient contact before the first conviction, and an increased number of miscarriages (see table 6).

Since the subjects were not matched for race or any other variable, we thought it important to investigate racial differences. A comparison of variables on the basis of race revealed no major differences between blacks and whites for most of the variables. For example, it was

[2] The phi coefficient is a measure of correlation that is used with dichotomized variables and produces a value on the same scale (i.e., −1 to +1) as the usual product-moment correlation (12). It was used in this study because all prisoners were put in either the violent or nonviolent category for each index of violence.

[3] Neurological disorders were grouped into five categories: 1) seizure disorders, convulsions, epilepsy; 2) major central nervous system disorders other than seizure disorder, such as brain tumor, meningitis, encephalitis, hemorrhage, cerebral palsy, chorea, and multiple sclerosis; 3) migraine headaches or severe, frequent headaches; 4) delirium; and 5) speech and reading difficulties. A score was given for each category and the number of positive categories was summed for each subject.

[4] The dyscontrol syndrome has only recently been recognized and described in detail (13, 14). It is defined by Monroe (14) as a series of disordered acts that interrupt an individual's typical life-style and that appear both out of character for the individual and inappropriate to the situation.

[5] Homosexuality, for purposes of this study, is defined as the agreement between two independent questions on the social worker's survey. The first was "Before entering the reformatory, which of the following would you say was the most satisfactory way of attaining sexual pleasure?" Homosexuality was indicated by checking the answer "Having sex with women." The second question was "Would you say that any of the following [items] pertain to you?" The inmate was considered homosexual if she checked the answers indicating homosexuality on both questions.

TABLE 4
Correlation Matrix for the Five Measures of Violence

Measure of Violence	Correlations			
	MMPI	Correctional Officers	Prison Administration	Sentence Length
Self	−.40	.12	.09	.11
MMPI		−.17	−.01	.23
Correctional officers			.10	.22
Prison administration				.67

found that among violent blacks the frequency of family violence was not greater than among violent whites. Nevertheless, some variables do show differences between the groups. Among these, loss of one or more parents before age ten appears to be higher for black subjects, whereas divorce of parents appears to be higher among white subjects.

Regarding the nearly significant variables, i.e., those variables for which four out of five measures of violence were higher in either direction, the variables associated with violent behavior were divorce of parents, violence in the family, suicide attempts, menstrual problems, increased use of medically prescribed drugs (indicative of previous medical contact), head injury after the age of ten, some neurotic traits of childhood, and two scales of the MMPI, hypomania and psychopathic deviate.

The variables associated with nonviolence were psychiatric contacts before first conviction, drug addiction, and alcoholism, as well as cancer, diabetes, tuberculosis, heart disease, and an increased frequency of surgical interventions among immediate relatives.

Nine abnormal EEG tracings and six borderline tracings were similarly distributed in the violent and in the nonviolent groups across the five measures of violence. None of the four basic dermatoglyphic patterns investigated showed any significant differences between the two groups.

DISCUSSION

One of the most striking findings of our investigation was the disproportionately high prevalence of medical disorders of all kinds in this population. Seizure disorders, headaches, heart disease, gonorrhea, congenital abnormalities, tuberculosis, and allergies were reported by the inmates at frequencies well above those in any general population statistics. Head injury has been reported on many occasions to be rather prevalent in prison popu-

TABLE 5
Variables Associated with Violence on All Five Measures

Variable	Measures of Violence				
	Self	MMPI	Correctional Officers	Prison Administration	Sentence Length
Mean number of neurological disorders in family					
Violent	11.6	14.8	12.0	13.0	11.2
Nonviolent	10.3	13.0	9.6	10.0	10.8
Mean number of other medical disorders in family					
Violent	1.1	1.5	1.2	1.3	1.1
Nonviolent	1.0	1.3	1.0	1.0	1.0
Dyscontrol present (percentage)					
Violent	12.5	9.1	10.5	17.9	13.2
Nonviolent	6.1	8.7	7.1	7.7	6.8
Easy access to weapons (percentage)					
Violent	79.2	65.5	67.4	72.7	73.8
Nonviolent	43.6	64.0	54.5	58.5	55.6
Homosexual (percentage)					
Violent	82.1	82.2	80.8	93.3	79.3
Nonviolent	68.8	78.3	68.8	69.2	73.3
Mean age at paternal loss					
Violent	10.3	10.8	11.1	12.9	11.2
Nonviolent	16.4	10.9	16.6	13.0	15.8
Mean age at maternal loss					
Violent	9.0	4.2	9.6	10.8	9.3
Nonviolent	21.3	12.6	21.0	20.1	20.8
Lost mother before age ten (percentage)					
Violent	10.4	12.1	8.1	14.3	12.1
Nonviolent	5.4	8.7	6.5	3.7	5.3
Severe punishment from parents (percentage)					
Violent	18.8	20.0	20.0	26.7	23.1
Nonviolent	15.8	12.0	15.0	15.6	13.6

TABLE 6
Variables Associated with Nonviolence on All Five Measures

Variable	Measures of Violence				
	Self	MMPI	Correctional Officers	Prison Administration	Sentence Length
Mean number of miscarriages					
Violent	0.7	0.4	0.7	0.8	0.8
Nonviolent	1.0	0.9	1.0	0.9	1.1
Neurotic depression present (percentage)					
Violent	28.6	27.3	28.1	28.6	22.6
Nonviolent	34.7	32.6	40.5	32.3	36.4
Psychiatric outpatient care before conviction (percentage)					
Violent	26.9	23.1	19.0	25.0	23.5
Nonviolent	42.9	38.9	57.1	44.0	47.4

lations (15). Our data have supported this finding in a female prison group in which 75.6 percent of the inmates suffered head injury. Surgery (other than gynecological) was reported by 81.6 percent of the inmates. When neurological disorders are summed together, 40 percent of the subjects reported suffering from such disorders. Speech and reading difficulties were also reported in about 8 percent of the subjects. Neurological examinations revealed scattered positive signs and the EEG results have shown a rather high degree of both abnormal and borderline tracings.

We would like to emphasize several points applicable to the study of criminality, violence, and prisoners in general. First, it is important that objective rather than subjective instruments be used in obtaining information. This is not a new suggestion. As early as 1798, Pinel emphasized the need for a standard collection of data on mental patients to help understand mental disorders. Over 170 years later the same comment could be made about the study of criminality. We face a more complex problem, perhaps, but the same methodological principles apply. It is of limited value to continue the study of criminality unless objective measures are used.

In addition, due to the ambiguity of the concept of violence, there is little value in studying only one of its aspects. Our approach has therefore been to use several independent measures of violence.

The second point to be emphasized is the value of a multidisciplinary approach to the study of violence and crime. We have demonstrated how, by combining the expertise of several disciplines—using medical interviews and examinations (neurological and gynecological), biological tests (dermatoglyphics and EEGs), psychological tests, psychiatric interviews, and interviews by social workers—we found these prisoners to be extremely ill in many ways. Other investigators (1, 3, 7, 8, 16) have found that there is almost always something unusual about criminals, biologically or otherwise. The most interesting question, however, remains unanswered. What associations exist between different classes of variables? Our study provides a preliminary answer to this question.

The third methodological point is that incidence—"the number of cases of the disease which came into being during a specified period of time" (17)—rather than prevalence—"the proportion of that population which exhibits the disease at that particular time" (17)—should be used in the study of criminal and violent behavior. Obviously if prevalence data are obtained, the sample includes all the inmates at a given moment and is heavily weighted with individuals with long sentences. Such individuals are often the most legally deviant and are perhaps the most deviant in other respects as well—biologically, for example.

We believe that serious consideration of these methodological points will have a profound effect on the quality of data gathered. The findings will have value as etiological studies and may also influence the delivery of medical care to this population.

Of the specific results of comparing violent and nonviolent groups in this population, the anamnestic variables that seem to be associated with the presence of violence were the higher prevalence of some medical disorders in the relatives of the violent subjects and strong evidence of certain psychodynamic events in the lives of the violent individuals, such as loss of parents at an early age. Although early loss of either parent was associated with violent behavior, maternal loss occurred earlier than paternal loss in the lives of these inmates. This suggests that early maternal loss is strongly associated with violent behavior for this group of women prisoners.

The finding that both medical and psychodynamic events are associated with violence provides additional evidence of the need for a multidisciplinary approach to the study of violence. Interesting and unexpected findings frequently result. For example, an analysis of factors not significantly associated with violence shows a higher frequency of psychiatric outpatient contacts before incarceration in the nonviolent group and a higher frequency of depression. This mixed picture of associations with violent behavior is supported by studying near-significant data. The factors associated with the violent group include a variety of psychiatric and medical problems: higher frequency of parental divorce; violence in the

family; suicide attempts; increased frequency of menstrual problems; increased use of medically prescribed drugs; head injury after the age of ten; the triad of "cruelty to animals, enuresis, and pyromania"; and the MMPI scales for hypomania and psychopathic deviate.

For the most part, the nonviolent group showed more evidence of psychiatric pathology (psychiatric hospitalization, psychiatric outpatient contacts before first conviction, drug addiction, and alcoholism) but also showed evidence of nonneurological medical problems (cancer, diabetes, and tuberculosis in relatives; surgical interventions and heart disease in the inmates). These data support the notion that there is no single variable associated with violence that is most important. Although at the higher levels of significance loss of one or more parents (more specifically maternal loss) and neurological disorders in relatives appear to be strongly associated with violent behavior, it is the interaction of these variables that influences the eventual violent act.

Violent behavior is a complex phenomenon with many causes. Unless a multidisciplinary approach to the study of criminality and violence is used, investigations within isolated disciplines will continue to be of limited value.

REFERENCES

1. Hill D, Waterson D: Electroencephalographic studies of psychopathic personalities. J Neurol Psychiatry 5:47, 1942
2. Stafford-Clark D, Taylor FHM: Clinical and electroencephalographic studies on prisoners charged with murder. J Neurol Neurosurg Psychiatry 12:235–350, 1949
3. Williams D: Neural factors related to habitual aggression. Brain 92:503–520, 1969
4. Taylor DC: Aggression and epilepsy. J Psychiatr Res 13:229–236, 1969
5. Smith JO: Criminality and mental retardation. Training School 13 (2):74–80, 1962
6. Penrose LS: The contribution of cytogenetics to clinical psychology, in Modern Trends in Psychological Medicine, Series 2. Edited by Price JH. New York, Appleton-Century-Crofts, 1970, pp 1–23
7. Price WH: XYY syndrome. Proc R Soc Med 61:654, 1968
8. Gibbens TC: The delinquent and his brain. Proc R Soc Med 62:57–60, 1969
9. Davis R, Sines JO: Antisocial behavior pattern associated with specific MMPI profile. J Consult Clin Psychol 36:229–234, 1971
10. Hollingshead AB: Two-factor index of social position. New Haven, 1957 (processed)
11. Holt SB: The Genetics of Dermatological Ridges. Springfield, Ill, Charles C Thomas, 1968
12. Peatman JG: Descriptive and Sampling Statistics. New York, Harper, 1947
13. Menninger K: The Vital Balance. New York, Viking Press, 1970
14. Monroe RR: Episodic Behavioral Disorders: A Psychodynamic and Neurophysiologic Analysis. Cambridge, Harvard University Press, 1970
15. Roth HL, Rollings A, Ervin FR: Men who are violent in prison: a comparative study. Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex, May 1–5, 1972
16. Wolfgang MI, Ferracuti F: The Subculture of Violence. London, Tavistock Publications, 1967
17. McMahon B, Pugh FT: Epidemiology: Principles and Methods. Boston, Little, Brown and Co, 1970

Answers to Questions of the Month

Page 960. Question 1:D; Question 2:B.

Some Aspects of the History of Swiss Psychiatry

BY MANFRED BLEULER, DR. MED.

After reviewing some of the major accomplishments of individual Swiss psychiatrists, the author presents his view that great contributions to the progress of science, and particularly psychiatry, are closely related to the historical and cultural milieu in which the scientist works. As a result of the special circumstances prevailing at various times in their history the Swiss were able to make important contributions to the advancement of psychiatry; among them were an emphasis on the psychiatrist's developing a close relationship with his patients, their relatives, and their social group.

THE GREAT CONTRIBUTIONS by men to the progress of science, medicine, and especially psychiatry are closely related to the history and the cultural and social conditions of the social group to which these men belong. As part of my brief presentation of some aspects of the history of Swiss psychiatry, I should like to sketch its roots within Swiss history.

First I will enumerate some of the main Swiss contributions to psychiatry. Perhaps the most important of these contributions was the result of the work of Heinrich Pestalozzi—not a psychiatrist, to be sure, but a great pedagogue and psychotherapist of inborn genius. As early as the end of the 18th century he espoused ideas regarding education and mental health that sound very similar to modern conceptions. He stressed the importance of the emotional relationship of the child to his parents and teachers. He taught what maternal deprivation means to a child, how sound human development depends on the teaching of rationality and humanity, and how unsound development results from the teaching of irrationality and false emotional reactions.

A second contribution concerns the prevention and treatment of cretinism. Until far into the last century cretinism, goiter, deafness, and mental retardation due to iodine deficiency and poor hygienic conditions were prevalent in many Alpine valleys; up to half of the inhabitants were affected. The care of the mentally retarded, cretinous child in Switzerland was pioneered by Guggenbühl at the beginning of the last century; his work was followed by studies carried out by others on the etiology and prevention of cretinism. Thanks to the use of iodine and an improvement in general hygiene, cretinism, goiter, and feeblemindedness resulting from cretinism disappeared, but many other mentally retarded children remained to be cared for. Devotion to their care has retained a high priority in Switzerland since the time of Pestalozzi and Guggenbühl.

Next came the Swiss contributions to modern medical psychotherapy. These were initiated by studies on hypnosis by Auguste Forel and Eugen Bleuler in the 1880s in connection with the great psychiatric schools of Charcot in Paris and Liébeault and Bernheim in Nancy. At the same time these psychiatrists demonstrated the effectiveness of group therapy with alcoholics.

This arousal of psychotherapeutic enthusiasm was the background for psychoanalytic research work in Switzerland. It was facilitated by Eugen Bleuler's interest in the early neurological work on aphasia by Sigmund Freud; Bleuler had become acquainted with Freud in connection with discussions of this work. For these reasons, the clinic at Zurich became the first university institute willing to collaborate with Freud and to study his theories. A close personal relationship developed between the psychiatric team in Zurich and Freud. This greatly aided the progress of the psychoanalytic movement and its recognition by academic circles; as Freud repeatedly mentioned, during an early phase of his teaching most of his pupils had made his acquaintance through the clinic at Zurich. At the same time that the Zurich clinic was contributing to the propagation of Freud's ideas, it was evaluating these ideas critically, and this criticism proved to be correct in the light of further developments and particularly in the light of new psychological knowledge coming from biologists' studies of animal behavior. For example, it was taught in Zurich that blocking of human sexuality and human aggression was not due exclusively to the teaching of morality in modern civilization, but that there are other strong elementary biological drives that counteract the sexual and aggressive drives.

The early psychoanalytical studies were used by Eugen Bleuler in forming the concept of schizophrenia, but perhaps the most brilliant result of the early psychoanalytical work at Burghölzli involved Carl Jung, who was a resident there at the time. Starting in cooperation with Eugen Bleuler and Freud, he created his own doctrines, which later were to become famous and to influence not only psychiatry and psychotherapy but also philosophy, pedagogy, and theology.

Other important Swiss contributions to psychiatry and psychology concern projective testing, the principles of

Based on a paper read at the First International Film Festival on Switzerland and C.G. Jung, University of Texas Health Science Center, San Antonio, Tex., October 15, 1972.

Dr. Bleuler is Professor of Psychiatry, University of Zurich, and former Director, Psychiatric University Clinic, Burghölzli, Zurich. Address reprint requests to him at Bahnhofstrasse 49, CH-8702 Zollikon, Switzerland.

which were formulated nearly 200 years ago by Lavater, a clergyman. He taught that the personality of a man is projected in everything he does. Lavater's teachings became the basis of graphology and modern projective tests. His ideas were taken up by Jung and Eugen Bleuler, who first used the old word-association test in a modern sense. An even more important contribution in this area was made by Rorschach. He developed his tests involving interpretations of ink blots while he was working in a rural psychiatric hospital; he did this without any help from others and without research funds.

The Swiss psychiatrist Binswanger and his pupils have also contributed much during the last 50 years to the growth of another psychiatric doctrine that has become well known—psychiatric phenomenology.

I might mention very briefly some of the other Swiss contributions to psychiatry within recent decades: the introduction by Klaesi of prolonged narcosis, the first modern physical treatment of severe psychosis; some early contributions to our knowledge of psychopharmacology, such as the work on reserpine and the discovery of LSD; longitudinal studies of the courses of psychiatric diseases, particularly of schizophrenia, manic-depressive psychoses, and the neuroses; studies of the hereditary background and familial conditions of psychiatric patients; and studies of the significance of endocrine function to psychic life.

RELATIONSHIPS WITH PATIENTS

If one surveys these and the many other contributions of Swiss psychiatrists to psychiatry, one discovers that they have one aspect in common: they involved a close personal relationship between the psychiatrist and his patients and they were undertaken without (or with a minimum of) financial aid. They were carried out by clinical psychiatrists during routine medical work with patients and often during evening hours, Sundays, and vacations. There are reasons for this. Before World War I and particularly during the 17th and 19th centuries, Switzerland was a poor country. Money and magnificence existed in the capitals of the surrounding countries—at the courts of emperors, kings, and princes in France, Italy, Germany, and Austria—but not in Switzerland. For many centuries the idea prevailed in Switzerland that attention to culture, the arts, and science (especially research in biology and medicine) was possible only in the capitals of the larger countries. While the care of the sick was carried out fairly well, hardly anything was done for research; large sums for research purposes were not granted by the state, the universities, or by rich private citizens. Research in Switzerland up to quite recently meant investigating on one's own in the time left after performing professional duties.

The tendency of Swiss authorities to neglect research outlived the centuries of poverty. It lasted particularly long in the field of psychiatry, where it has been overcome only recently. But this neglect has had its advantages; it has directed the interest of psychiatrists toward the patients. If small Switzerland was able to make a modest contribution to world psychiatry, it has mostly been due to the close personal relationship between Swiss psychiatrists and their patients. This relationship was facilitated by the absence of such social barriers between psychiatrists and the general population as existed in other countries. Swiss psychiatrists came from all social classes; they had all gone to public rather than private schools; they had all been trained in the same way for military service—they had slept on straw for many months as had every other private. They were less separated from the general population and from their patients by birth, nobility, fortune, or academic career than was the case in other countries.

"KLEINJOGG"

Two examples illustrate this. First there was Jakob Guyer, called *Kleinjogg* (Little Joe); he had great influence on Swiss psychiatry and even on American psychiatry, although he was not a psychiatrist but a poor farmer who could hardly read or write. Born in the country near Zurich in 1716, this modest, simple farmer won international respect during his lifetime; Goethe visited him and called him "one of the most magnificent creations this earth has brought forth." Similar praise was given to him by many noblemen and officials who visited him.

From what did the fame of this simple man result? At this time farmers and uneducated men observed very traditional ways of living, but Kleinjogg pondered over his work and his way of living. If he concluded that a different course of action than the traditional one was appropriate, he adopted it without hesitation. At that time in history this was considered remarkable; no initiative was expected from a peasant. People said to him, "We foresee nothing good, since you depart in every way from the practices of our pious fathers." But he did not mind this kind of talk. He improved farming methods, took the lead in crop rotation and better fertilization, lightened heavy soil by mixing it with sand, introduced the cultivation of potatoes in Switzerland, and many other things. He was able to express his thoughts in clear language, saying, for example, "Man must take the shortest way."

Even more important than his agricultural activities were his psychological teachings. He stated, "To reform a farm one must begin by the moral reform of its inhabitants." Early and late, Kleinjogg thought of how men could remain happy and mentally healthy. His insight anticipated the most important principles of mental hygiene; progress comes from teamwork, he stated, gentry and peasants must collaborate. He worked side by side with his own and his brother's children and farmhands because he believed teaching without example was to no avail. Once he employed a farmhand who had been discharged by his neighbor because of laziness. Kleinjogg was satisfied with the farmhand's work. He explained that the boy had become lazy because his former master had despised field work and avoided the work he used to give the boy. Kleinjogg worked alongside the boy and in-

fluenced him by his own joy in the work.

Kleinjogg was convinced that parents' influence on their children was decisive for personal development. He kept his children near him as much as possible in order to help them develop a healthy life pattern. One physician who knew him very well stated, "In his household there ruled only one heart and one will." This was, in short, the commonsense philosophy of the farmer Kleinjogg.

Such a philosophy greatly influenced Swiss psychiatry; among the friends and admirers of Kleinjogg were Pestalozzi and Lavater, whose significance for psychiatry I have already mentioned. In addition there were connections between Kleinjogg's teachings and American psychiatry. Adolf Meyer, one of the leading American psychiatrists in the first decades of this century, immigrated to the United States from Switzerland as a young man. His grandfather, a stove builder, was close to Kleinjogg's son, who operated the farm he had inherited along the same lines as his father had. Kleinjogg's farm later passed into the possession of Meyer's uncle and there followed a number of marriages between Kleinjogg's descendants and Meyer's descendents. Close relatives of Adolf Meyer still carry on Kleinjogg's farm. During his childhood Meyer knew his grandfather, who had lived intimately with Kleinjogg's heritage. His ties with it remained; after Meyer's mother was widowed she lived on Kleinjogg's farm.

It was among Meyer's great accomplishments that he helped eliminate the rigid traditions that were hindering psychiatry. He made possible an unprecedented evaluation of mental disturbances by breaking out of the stiff frames of the old nosology. Untrammeled by the old ways of thinking, Meyer observed his patients closely and drew his own conclusions. He took "the shortest way," as Kleinjogg had taught. "I was quite astonished to find him free of old prejudices," had been said of Kleinjogg by a friend. Exactly the same was written of Meyer by visitors to his clinic in Baltimore. Kleinjogg's high goals for mankind as well as his high esteem for family life and human relationships corresponded to Meyer's psychotherapeutic goals. According to Kleinjogg the child must grow to maturity through the example of the parents. According to Meyer, mental patients can recover in the climate of sympathy and brotherhood created by the physician.

INFLUENCE OF THE RURAL POPULACE

The second example of the lack of class separation between psychiatrists and patients in Switzerland involves Swiss history. During the 18th century the freedom of the country people around Zurich was restricted. Except for a few years after the French revolution this area was ruled very strictly by the aristocratic families of Zurich. Among the restrictions that were most resented was the denial of access to better schooling, to professional instruction in handicrafts, and to academic studies. Many of the academicians, public functionaries, clergymen, and physicians who were sent from the city to the country villages were not very able; the best men preferred to remain in the city. Along with the resentment against the aristocratic academicians, there arose a great longing for higher education and for participation in the progress of science and medicine. The fact that the peasants did their best to give themselves a higher education is shown in their large libraries, which have been preserved to the present time.

In 1830 the aristocratic government was overthrown by the people, a democratic constitution was introduced, and men from the country entered the government. One of the most cherished wishes of the people at that time was to create a university that would be open to any intelligent citizen. Rural people hoped that their sons would be better academicians and particularly better doctors than the aristocratic ones. The university was created, but disappointment followed. Zurich did not have an academic tradition, so the university faculty had to be chosen from among Germans. Most of them could not make good contact with the people they taught and treated. This was made particularly difficult by the language barrier; in Switzerland there is a centuries-old uneasiness in social contact with persons who speak German and do not speak the Swiss dialect. In particular, there was another difficulty with regard to the German professors of psychiatry, Von Gudden and Hitzig. They were more interested in brain pathology and less interested in contact with psychotic patients. There was a feeling that the newly elected German professors at the university psychiatric clinic (as at the other clinics) looked down on the simple country people and that a mutual understanding of intimate matters was impossible.

While Eugen Bleuler was a college student a young girl from his village was struck with a severe mental disorder and was brought to the nearby university psychiatric clinic for treatment. During their visits the relatives of the girl could not establish personal contact with the German director of the clinic. The country people felt certain that physicians would have been able to help this young patient (and many other mental patients) if they understood their language and took the time to speak with them. They stressed the point that a mental patient would be helped if the physician understood the meaning of his seemingly confused language. Eugen Bleuler was impressed by the feeling of the farmers that a psychiatrist who understood the patients' native language and was ready to listen to them would be a better psychiatrist than one who spoke another language and was not willing to establish contact with his patients.

Eugen Bleuler became the first professor of psychiatry in Zurich who spoke the local language; his interest was directed toward understanding what his patients wanted to say and toward listening to their hopes, fears, and worries. If he was able to make a contribution to psychiatry, it was due to his zeal in understanding what the patients' confused language and behavior really meant. He found that even in seemingly deteriorated schizophrenic patients a normal intellectual and emotional life persisted, although it was hidden by the unsound behavior. From this point of view, and in cooperation with many other psychiatrists, he helped open the way to a more hu-

mane understanding of the mentally sick and to psychodynamic psychiatry.

CONCLUSIONS

If one ventures to draw a general conclusion as to what the history of Swiss psychiatry teaches, it would be that it is important to work with the patient personally and as a full-time physician when one is practicing psychiatry and investigating mental distress. Psychiatry is in need of research in biology, sociology, philosophy, and so on. However, progress in helping the patient and in the science of mental diseases will be attained only if many psychiatrists remain in personal communication with patients, their relatives, and the social group from which they come.

References for Questions of the Month

Pages 960 and 990:

Question 1: Wender PH, Rosenthal D, Zahn TP, Kety SS: The psychiatric adjustment of the adopting parents of schizophrenics. Am J Psychiatry 127:1013–1018, 1971

Kety SS, Rosenthal D, Wender PH, Schulsinger F: Mental illness in the biological and adoptive families of adopted schizophrenics. Am J Psychiatry 128:302–306, 1971

Question 2: Spitz RA, Wolf KM: Anaclitic depression: an inquiry into the genesis of psychiatric conditions in early childhood, II. Psychoanal Study Child 2:313–342, 1946

Linn L: Clinical manifestations of psychiatric disorders, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, p 569

Suicidal Behavior in Edinburgh and Seattle

BY HERBERT S. RIPLEY, M.D.

Suicidal behavior in Seattle and Edinburgh, Scotland, was compared on the basis of data obtained from vital statistics and interviews. There were many similarities between those making attempts in the two places, but marked differences were observed in the method used and in the incidence of alcoholism and drinking at the time of the act. The author identified psychosocial characteristics of Edinburgh that might account for its having a lower suicide rate than Seattle. These included a lower incidence of alcoholism, a more integrated and less mobile society, a smaller percentage of foreign-born and racial minorities, and a cultural tradition of more controlled and less violent behavior. Moreover, the less lethal method of drug overdose was more often used in Edinburgh than in Seattle.

A NUMBER OF SOCIOLOGICAL INVESTIGATIONS have been made of suicide in specific places, such as those of Sainsbury (1), Bohannan (2), Schmid and Van Arsdol (3), McCulloch, Philip, and Carstairs (4), Kessel (5), Robins and his colleagues (6), Dorpat and Ripley (7, 8), and Hoskin, Friedman, and Cawte (9). Studies contrasting suicidal behavior in different places have depended largely on vital statistics from large groups to make comparisons and draw inferences. The studies of Durkheim (10), Cavan (11), Dublin (12), Carstairs and Brown (13), and Kato (14) fall into this category.

Few have based their research on comprehensive interviews covering a wide spectrum of the medical, psychological, and sociological background. Hendin (15) based his comparison of suicidal behavior in Denmark, Norway, and Sweden on data gathered from relatively unstructured interviews with patients who had attempted suicide. Few studies have compared various psychosocial aspects of communities in different countries to account for differing suicide rates. One study in this category, that of Faberow and Simon (16), used the psychological autopsy method to examine suicide in Los Angeles and Vienna.

This investigation is aimed at comparing a number of variables for groups of people attempting and completing suicide in two cities that are widely separated both geographically and culturally—Edinburgh, Scotland, and Seattle, Wash.

SETTING

Seattle and Edinburgh are cities with many differences but also many similarities. In 1970, the population of Seattle was 530,831 and that of Edinburgh was 464,764. The weather in the two cities is similar; both have many cloudy days and few extremes of hot and cold temperatures. Both cities are seaports and centers of higher education and commerce for their surrounding regions. They have active telephone services designed to help suicidal and other emotionally upset individuals.

There are a number of differences. A high percentage of people in Edinburgh were born and raised there, whereas there is a great movement of people in and out of Seattle. In Seattle 8.4 percent of the people are from racial minority groups; in Edinburgh, over 99 percent are Caucasian. There is more social unrest and violence in Seattle, as indicated by higher rates of crime. In Edinburgh there is better social integration and greater respect for the law. Although acts of suicide are illegal in the State of Washington, prosecution has not been carried out. In Scotland, suicide has not been an offense for many years.

METHOD

Through interviews, Dorpat and Ripley (7, 8) had gathered data on the medical and psychosocial background of 121 consecutive patients (39 men and 82 women) who had made suicide attempts and who were admitted to the Harborview Medical Center in Seattle during two three-month periods in 1957 and 1958. In 1970, using the same collection method, one of the participants in the Seattle study obtained similar data on 100 unselected patients (39 men and 61 women) admitted to a ward of the Royal Infirmary of Edinburgh that has been described by Kessel (5), Aitken and Carstairs (17), and Kreitman, Smith, and Tan (18). Since all reported attempters in Seattle are brought to Harborview Medical Center, a high proportion of suicide attempters come to

Dr. Ripley is Professor, Department of Psychiatry, University of Washington School of Medicine, Seattle, Wash. 98195.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The author wishes to thank Dr. I.M.K. Ovenstone for supplying data on the completed suicides in Edinburgh; and, for their support, Dr. Henry Matthew, Regional Poisoning Treatment Center, Royal Infirmary, Edinburgh; Prof. G.M. Carstairs and Dr. Ian Oswald, Department of Psychiatry, University of Edinburgh; and Dr. Norman Kreitman, Medical Research Council Unit for Epidemiological Studies in Psychiatry, Royal Edinburgh Hospital. Thanks are also due to Dr. Theodore L. Dorpat for the use of data from previous collaborations and to Dr. Hans O. Doerr, Associate Professor of Psychiatry, University of Washington, for assistance in the statistical analysis.

TABLE 1
Age Distribution of Suicide Attempter Groups in Percentages

Age	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Below 15	14	3*	5	2	7	2
15–24	23	26	28	31	26	29
25–34	16	33**	26	16	24	23
35–44	16	10	20	18	20	15
45–54	11	10	9	16	9	14
55–64	2	8	5	10	4	9
65–74	14	10	5	5	7	7
75 and over	2	0	1	2	2	1
Mean age	38	37	33	37	35	36

*Comparison between groups $p < .02$.
**Comparison between groups $p < .01$.

this hospital. A survey of case dispositions in Edinburgh has indicated that approximately 80 percent of Edinburgh's suicide attempters are hospitalized in the Royal Infirmary (19).

Records from the Coroner's Office (20) for 114 consecutive suicides (78 men and 36 women) in Seattle during the last six months of 1957 and the first six months of 1958 as previously reported (7, 8) were evaluated. Suicide records (21, 22) of the city of Edinburgh for the year 1970 were studied and 91 consecutive persons (47 men and 44 women), independently judged to be suicides by Dr. I.M.K. Ovenstone, were used for comparison with the Seattle group. Additional information was gained from interviews with their physicians about their social background, medical and psychiatric history, and the circumstances of the suicidal act. In Seattle, the relatives of the deceased were also interviewed.

Since there is a considerable time interval between the collection of the data in the two cities, hospital reports and government vital statistics were examined to evaluate trends from 1958 to 1970 in regard to age, sex, and method (20–23) of both those making attempts and those completing suicide.

The data were treated statistically by 2×2 chi square ($df = 1$). Statistical significance was tested against a two-tailed distribution. Only values of $p < .05$ or better were considered significant.

SUICIDE ATTEMPTS

Comparisons were made of the suicide attempts in the two cities. The mean ages for both men and women were similar (table 1). A comparison of the proportion of those in each age group indicates that most were between the ages of 15 and 44 in both cities. There was an appreciable number of men under 15 in Seattle, and a greater incidence in men between 25 and 34 in Edinburgh. The total populations of the two cities did not show significant differences in sexual distribution. Approximately twice as many women as men in both places (68 vs. 32 percent in Seattle and 61 vs. 39 percent in Edinburgh) made attempts.

Most of the patients in both cities had some degree of affective disturbance, which ranged from mere feelings of depression that were not diagnosed as depressive illness to a reactive depression to a psychotic depressive illness. There was a significantly higher incidence of alcoholism and problem drinking in both men and women in Seattle, and of drinking at the time of the act for women in Seattle (table 2). The criteria of Jellinek (24) were used in both places.

In both cities, the most common precipitating events were domestic problems, lovers' quarrels, poor physical health, loss through death, and financial worries. The methods used are shown in table 3. There were significant

TABLE 2
Alcohol Involvement in Suicide Attempter Groups in Percentages

Problem	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Alcoholism or problem drinking	76	41*	41	20**	52	28*
Drinking at time of act	43	38	43	16*	43	25*

*Comparison between groups $p < .001$.
**Comparison between groups $p < .01$.

TABLE 3
Method of Suicide Attempter Groups in Percentages

Method	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Poisons and drugs	26	90*	70	87**	55	88*
Cutting	26	3*	12	0**	17	1*
Jumping	8	0***	3	0	5	0
Strangulation	8	0***	3	0	5	0
Gunshot	15	3**	3	0	8	1***
Asphyxia	15	3**	3	3	8	3
Drowning	0	0	2	2	2	1
Miscellaneous or more than one method	3	3	2	8	3	6

*Comparison between groups $p<.001$.
**Comparison between groups $p<.01$.
***Comparison between groups $p<.05$.

differences, especially between the men, in the two cities. In Edinburgh, 88 percent of the total group used poisons and drugs, and in Seattle, 55 percent. In Seattle, other methods frequently used were cutting, shooting, inhaling gas, jumping, and hanging. There was a considerable difference in methods used by the men and women in Seattle. This was not true of Edinburgh, where 90 percent of the men and 87 percent of the women used poisons or drugs. In Seattle, a higher percentage of men used cutting, jumping, strangulation, asphyxia, and shooting, and a higher percentage of women used poisons or drugs.

Other findings that were characteristic of the groups in both cities included a low incidence of church membership and attendance and a high incidence of poor relationships with parents, broken homes, unemployment, and changes of residence. The findings in the present Edinburgh group are in agreement with the study of Bruhn (25), who made a comparative study of social disorganization in those attempting suicide and other patients referred for psychiatric treatment in Edinburgh.

COMPLETED SUICIDES

The suicide rate was higher in Seattle than in Edinburgh (20.8 and 15.0 per 100,000 of total population, respectively). In both cities, the rates were approximately twice those of their countries as a whole (United States, 11.0, and Scotland, 8.0). The sex distribution showed a marked contrast, with twice as many men as women in Seattle, and almost equal numbers of each sex in Edinburgh killing themselves (table 4). In recent years, an increasingly higher proportion of women have committed suicide in Edinburgh (22), but the ratio has remained relatively constant in Seattle. These findings (23) may be influenced partially by the methods used. In Seattle, a high proportion of men continue to shoot themselves, so that fewer with serious intent are saved. In Edinburgh, where in the past more men have used the more lethal method of gas, the same methods are now used by both sexes.

The age distribution as shown in table 5 indicates that there was no significant difference between the total mean ages of 50 for Seattle and 52 for Edinburgh. However, there was a significantly higher incidence among Seattle women in the 35- to 44-year-old age group and in Edinburgh women in the 55- to 64-year-old age group. The mean ages of 52 for men and 49 for women in Seattle and 50 for men and 54 for women in Edinburgh show that the men who committed suicide were somewhat older in Seattle and the women somewhat older in Edinburgh.

In regard to marital status, there was a higher proportion of the married of both sexes in Seattle. The proportion of married women was significantly high (table 6). The proportion of single men was higher in Seattle, and that of single women was higher in Edinburgh, but not to levels of significance. A significantly higher number of Edinburgh men and a somewhat higher proportion of the women were divorced or separated. The same proportion of men were widowered in both cities, but a significantly higher number of women were widowed in Edinburgh.

There are marked contrasts in the methods used in the two cities, and in the methods favored by the sexes (table 7). Poisons and drugs were the predominant method in

TABLE 4
Sex Distribution of Completed Suicide Groups in Percentages

Aggregates	Men		Women	
	Seattle	Edinburgh	Seattle	Edinburgh
In completed groups	68	52*	32	48*
In total city population	48	47	52	53

*Comparison between groups $p<.05$.

TABLE 5
Age Distribution of Completed Suicide Groups in Percentages

Age	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Below 15	0	0	0	0	0	0
15–24	10	7	9	2	10	4
25–34	12	15	14	9	12	12
35–44	16	15	25	2*	19	9
45–54	17	22	24	32	19	26
55–64	23	25	15	34**	20	31
65–74	12	13	8	18	11	15
75 and over	10	2***	6	2	9	2
Mean age	52	50	49	54	50	52

*Comparison between groups $p < .001$.
**Comparison between groups $p < .01$.
***Comparison between groups $p < .05$.

both men and women in Edinburgh. Shooting was the most frequent method in Seattle, especially among men (47 percent). Women in Seattle were more evenly distributed in their choice of methods. Shooting, poisons and drugs, strangulation, jumping, and asphyxia were all commonly used. There was a significantly higher use of poisons and drugs in Edinburgh, and of shooting and strangulation in Seattle. More women jumped from high places in Seattle.

The act took place outside of a medical institution in over 97 percent of cases in both cities. There was also no difference in the place where death occurred; about a tenth died after they reached a hospital. A higher but not significant number in Seattle (68 percent) were in an isolated setting at the time of their deaths than in Edinburgh (56 percent), and a significantly greater number in Edinburgh (43 percent) were alone but with someone in the same dwelling than in Seattle (26 percent).

There was little difference in the number who had seen general physicians within a year of death (88 percent in Seattle and 84 percent in Edinburgh). Approximately a fourth of the patients had seen psychiatrists in both cities. In both places, a high proportion (70 percent in Seattle and 48 percent in Edinburgh) suffered from a physical illness. Scrutiny of the reaction to illness revealed that physical illness was a frequent precipitating factor, especially in men, who are less able to accept feelings of helplessness and the economic and social deprivation that accompany chronic illness (7, 26). For many, particularly older people, illness means the approach of death and the intolerable uncertainty that can be dealt with by direct suicidal action.

A high proportion of the suicide victims in both cities had depressive illnesses. However, since the criteria for diagnosis in the categories of psychiatric illnesses vary considerably between Great Britain and the United States, it was not considered valid to make comparisons between the various diagnostic categories (27).

The differences in the pattern of previous attempts were not significant, except for the higher incidence of three or more attempts in Edinburgh (table 8). Again, this may have been influenced by the methods used. In Edinburgh, the seriously suicidal, who use drugs most commonly, may require more attempts to be successful

TABLE 6
Marital Status of Completed Suicide Groups in Percentages

Status	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Married	52	45	62	39*	55	42
Single	23	17	8	11	18	14
Divorced or separated	14	30**	14	18	14	24
Widowed	9	9	14	30**	11	19
Other or no information	1	0	3	2	2	1

*Comparison between groups $p < .01$.
**Comparison between groups $p < .02$.

TABLE 7
Method of Suicide for Completed Groups in Percentages

Method	Men		Women		Total	
	Seattle	Edinburgh	Seattle	Edinburgh	Seattle	Edinburgh
Poisons and drugs	8.9	57.5*	22.2	77.3*	14	67*
Cutting	1.3	4.3	2.8	0.0	2	2
Jumping	7.7	6.4	11.1	2.3**	8	4
Strangulation	10.3	6.4	16.7	0.0*	12	3**
Gunshot	47.4	4.3*	22.2	0.0*	40	2*
Asphyxia	12.8	17.0	11.1	15.9	12	17
Drowning	6.4	2.1	5.6	2.3	6	2
Miscellaneous or more than one method	5.1	2.1	8.3	2.3	6	2

*Comparison between groups $p<.001$.
**Comparison between groups $p<.05$.

than those in Seattle, who are initially successful with firearms. There was no significant difference between the sexes in the number of previous attempts.

In Seattle, there was a significantly higher proportion of those with alcoholic problems (68 percent and 45 percent for Seattle and Edinburgh respectively), using the criteria of Jellinek (24). Alcoholism has frequently been found to be associated with suicide (28–31). There is some evidence that alcoholism is more of a problem in the U.S. than in Scotland, and the two cities may be characteristic of their national cultures. For example, the death rates for cirrhosis of the liver per 100,000 population in 1967 were 14.1 for the United States and 4.4 for Scotland (32). There appears to be greater use of hard liquors and relatively less consumption of beer in Seattle than in Edinburgh. The more affluent people of Seattle are apt to drink whiskey made in Scotland, while the Scots are content to drink beer and ale, both of which are less conducive to the development of alcoholism. The use of alcohol preceding the act was not significantly different; it occurred in approximately a third of the cases in both places.

Whereas during a single year there were no homicides followed by suicides in Edinburgh, there were five (4.4 percent) in Seattle. There was a greater amount of violence and crime in Seattle. One indicator is the incidence of homicides, which was 6.8 per 100,000 for the United States and 1.2 for Scotland in 1967 (32).

In Edinburgh, there is a very small nonwhite population (less than 1 percent). There were no representatives of this population in the group being studied. In Seattle, with a nonwhite population of 8.4 percent, only 5.8 percent of the suicides were in this group.

In both cities, there was a high incidence in areas of the city where many old people lived alone and families lived in overcrowded conditions. In Seattle, 23.4 percent of the suicides were in the 14 centrally located census tracts, which contain, however, only 8.8 percent of the population (23). In Edinburgh, in a part of the city center comparable in many ways, the rates of suicide and attempted suicide were also high (22, 33). Suicidal behavior in this area of Edinburgh has been studied by McCulloch, Philip, and Carstairs (4).

In the older central area of Edinburgh, composed of seven wards, there is much substandard housing and social disorganization. The rates vary between 32 and 67 per 100,000 population. In comparable areas of Seattle, the rates vary between 32 and 117 per 100,000, with an average rate of 55.5 per 100,000. In contrast, the other wards of Edinburgh have rates between 6.3 and 27 per 100,000, and the other areas of Seattle have rates between zero and 40 per 100,000, with an average rate of 17.4 per 100,000.

In addition to those previously discussed, the common precipitating problems in both cities included difficulty with the law, unemployment, poor financial circumstances, quarrels with relatives or lovers, loss of relatives and close friends, excessive use of drugs, loneliness, and lack of recreational outlets.

DISCUSSION

It is now generally recognized that both social and psychological factors are important in suicidal behavior and that each is of varying significance in a given individual.

TABLE 8
Previous Attempts by Completed Groups in Percentages

Frequency	Seattle	Edinburgh
None	68	55
One	22	15
Two	4	7
Three or more	6	23*
Total	32	45

*Comparison between groups $p<.01$.

The task of evaluating a factor is compounded by the fact that a number of variables rather than a single factor may conspire in an individual or a society. Furthermore, there may be intricate interrelationships between the psychosocial characteristics.

The data from government and hospital reports in Edinburgh indicate that since 1958 there has been a marked increase in suicide attempts, especially in the younger age groups, but no appreciable change in the incidence of completed suicide (21, 22, 33). In Seattle, the incidence of completed suicide has been stable (20, 23). From the hospital data available in Seattle, there has also been no appreciable change in the incidence of attempted suicide.

There has been a marked increase in the use of drugs and a corresponding decrease in the use of domestic gas in both attempted and completed suicides in Edinburgh. In contrast, the methods used in Seattle have fluctuated somewhat from year to year but have not shown any decided change since 1958.

Methods are influenced by availability, cultural patterns, and individual psychological characteristics. Guns are more readily available in the U.S. than in Scotland. They are also more widely used in the U.S., not only for suicide but for such other violent actions as murder and armed robbery; these have a much higher incidence in the U.S. than in Scotland. In general, firearms are used more frequently by men than by women for all purposes, and this is reflected in the fact that twice as many men as women die of intentional self-inflicted gunshot wounds in Seattle.

On the other hand, sedatives and tranquilizers appear to be more frequently prescribed by physicians in Great Britain and are available at a small charge through the National Health Service. The idea of drug use as a method of suicide has become well established, and individuals of both sexes who are considering killing themselves naturally think of drugs.

Hanging is a favorite method in many countries (2, 9). It, along with drowning, jumping, and the use of cutting and piercing instruments (relatively constant as methods in Edinburgh and Seattle), appear to be strongly influenced by the personal background and drives of the suicidal individual in the American and British cultures. For example, one man who owned a gun hanged himself. A woman with a medicine cabinet well supplied with lethal drugs jumped out of a window. Durkheim (10) cited drowning as a relative constant as a means of suicide since its incidence does not vary from one season to another. Dublin (12) gave as an example of the psychological need for a specific method the case of the man who jumped from the Brooklyn Bridge in order to drown himself, then refused to be rescued until a policeman threatened to shoot him.

The complexity of variables prevents specifying the role of any one factor. However, tentative formulations or speculative hypotheses can raise questions for further investigations. For example, in Edinburgh an increasing proportion of women commit suicide so that the rates for the sexes are now almost equal. The changing role of women may have contributed to this narrowing gap between male and female rates in Edinburgh, and this social change may have been less marked in Seattle. However, as pointed out by McCulloch, Philip, and Carstairs (4), in order to test this hypothesis we should have to demonstrate that "emancipated" women have contributed disproportionately to the rise in female rates. In comparing the two cities, it would also be necessary to show that the change in social status has been greater in Edinburgh than in Seattle.

Perhaps the psychology of the people and the cultural settings in Edinburgh and Seattle are sufficiently similar that the contrasts are not sharp. This makes it difficult to define the factors that account for differences in the rates and patterns. For example, the manner in which children are raised does not appear to be clearly at variance in the two cities, except for possibly somewhat greater parental control in Edinburgh. In both places there is a high incidence of broken homes, which may create psychological problems conducive to later suicidal behavior.

However, as pointed out by De Vos (34), motives for suicide differ greatly in such diverse areas as Africa and Asia and among the Chinese of Singapore and Hong Kong. Bohannan (2) has pointed out that in several African cultures age appears to be venerated more than in Edinburgh or Seattle; the prevailing provocations for suicide are status and sexual adjustment problems in young adults. In a preliterate, primitive area of New Britain, where the suicide rate is especially high among young married women and young single men, feelings of shame, which are not prominent in the suicidal rates in Edinburgh and Seattle, are a dominant feature (9).

In the study contrasting Vienna and Los Angeles, both of which had high rates, the method of data collection was sufficiently different from our study to preclude making many meaningful comparisons (16). However, as in Edinburgh and Seattle, alcoholism, serious illness, and loss of loved ones were common problems.

In this study, data have not been obtained that permit quantification of the part played by the various psychosocial differences between Edinburgh and Seattle. However, some variables that other investigators have considered to be important in influencing suicide rates are likely to have played a role in Edinburgh's lower rate. Among the factors that are more characteristic of Edinburgh than Seattle are the following: a cultural tradition of less violence and more controlled behavior, with its roots in the family and school; a more integrated and less socially mobile society; a smaller percentage of foreign-born and racial minorities; a lower incidence of alcoholism; and less use of more lethal methods of self-destruction.

REFERENCES

1. Sainsbury P: Suicide in London, an Ecological Study. London, Chapman & Hall, 1955
2. Bohannan P: African Homicide and Suicide. Princeton, Princeton University Press, 1960
3. Schmid CF, Van Arsdol MD Jr: Completed and attempted sui-

cides: a comparative analysis. Am Sociol Rev 20:273–283, 1955
4. McCulloch JW, Philip AE, Carstairs GM: The ecology of suicidal behavior. Br J Psychiatry 113:313–319, 1967
5. Kessel N: Self-poisoning. Br Med J 5473:1265–1270, 5474:1336–1340, 1965
6. Robins E, Gassner S, Kayes J, et al: The communication of suicidal intent: a study of 134 consecutive cases of successful (completed) suicides. Am J Psychiatry 115:724–733, 1959
7. Dorpat TL, Ripley HS: A study of suicide in the Seattle area. Compr Psychiatry 1:349–359, 1960
8. Dorpat TL, Ripley HS: A study of suicide in King County, Washington. Northwest Med 61:655–661, 1962
9. Hoskin JO, Friedman MI, Cawte JE: A high incidence of suicide in a preliterate primitive society. Psychiatry 32:200–210, 1969
10. Durkheim E: Le Suicide: Etude de Sociologie. Translated by Spaulding JA, Simpson G. Glencoe, Ill, Free Press, 1951
11. Cavan RS: Suicide. Chicago, University of Chicago Press, 1928
12. Dublin L: Suicide, a Sociological and Statistical Study. New York, Ronald Press, 1963
13. Carstairs GM, Brown GW: A census of psychiatric cases in two contrasting communities. Journal of Mental Science (London) 104:72–81, 1958
14. Kato M: Self-destruction in Japan: a crosscultural, epidemiological analysis of suicide. Folia Psychiatr Neurol Jap 23:291–307, 1969
15. Hendin H: Suicide and Scandinavia. New York, Grune & Stratton, 1964.
16. Faberow WL, Simon MD: Suicides in Los Angeles and Vienna: an intercultural study of two cities. Public Health Reports 84:389–403, 1969
17. Aitken RCB, Carstairs GM: Psychiatric service in 1967 at the Royal Infirmary of Edinburgh. Scott Med J 13:388–393, 1968
18. Kreitman N, Smith P, Tan E: Attempted suicide in social networks. Br J Prev Soc Med 23:116–123, 1969
19. Kennedy P: Personal communication, May 1971
20. Sowers LM: King County Coroner's Report. Seattle, Seattle-King County Department of Public Health, 1967
21. Annual Reports of the Registrar General for Scotland, 1958–1970
22. Procurator's Fiscal Reports. Edinburgh, Scotland, 1958–1970
23. Meighan M: A Report on Suicides in Seattle, Washington, 1963–67. Seattle, Seattle-King County Department of Public Health, 1969
24. Jellinek EM: Alcoholism: phases of alcohol addiction. Q J Stud Alcohol 13:673–684, 1962
25. Bruhn JG: Comparative study of attempted suicides and psychiatric out-patients. Br J Prev Soc Med 17:197–201, 1963
26. Dorpat TL, Anderson WF, Ripley HS: The relationship of physical illness to suicide, in Suicidal Behaviors. Edited by Resnik HLP. Boston, Little, Brown and Co, 1968, pp 209–219
27. Cooper JE, Kendell RE, Gurland BJ, et al: Psychiatric Diagnosis in New York and London. London, Oxford University Press, 1972
28. Lemere F: What happens to alcoholics. Am J Psychiatry 109:674–676, 1953
29. Kessel N, Grossman G: Suicide in alcoholics. Br Med J 2:1671–1672, 1961
30. Palola EG, Dorpat TL, Larson WR: Alcoholism and suicidal behavior, in Society, Culture and Drinking Patterns. Edited by Pittman DJ, Snyder CR. New York, John Wiley & Sons, 1962, pp 511–534
31. Murphy GE, Robins E: Social factors in suicide. JAMA 199:303–308, 1967
32. World Health Organization: World Health Statistics Report, vol 22. Geneva, WHO, 1969
33. Aitken RCB, Buglass D, Kreitman N: The changing pattern of attempted suicide in Edinburgh, 1962–67. Br J Prev Soc Med 23:111–115, 1969
34. De Vos GA: Suicide in cross-cultural perspective, in Suicidal Behaviors. Edited by Resnik HLP. Boston, Little, Brown and Co, 1968, pp 105–134

Participation in the 1974 Annual Meeting May 6-10, Detroit, Michigan

A form for proposed contributions for APA's 1974 annual meeting was sent to all members in July. An abstract form was provided for those who wish to present a scientific paper, organize a special session or panel, or request the inclusion of a videotape or film. Another form was provided for those who wish to participate as officers of sessions or discussants of papers.

Interested members are urged to return the forms to the Office of the Chairman of the Program Committee, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009, as soon as possible. Persons who are not members may obtain the appropriate forms from the Office of the Chairman of the Program Committee. The final deadline for receipt of the completed forms is September 21, 1973.

Information on submitting papers for consideration for the New Research sessions will be made available at a later time.

A Law Enforcement Training Program in a Mental Health Center Catchment Area

BY EDWARD J. ROLDE, M.D., S.M.HYG., ELLSWORTH FERSCH, J.D., PH.D., FRANCIS J. KELLY, ED.D., SUSAN FRANK, M.S.W., AND MAURICE GUBERMAN

To increase understanding, communication, and cooperation between law enforcement officers and mental health workers in handling juveniles, the authors devised a training program and obtained the participation of ten law enforcement agencies. They made their presentations relevant to the local situation, used the expertise of the officers to good advantage, and focused on the pressure placed on the individual officer to perform his duties in the style of his department. The program was well received and influenced not only individual behavior but the policies of the participating organizations.

THIS PAPER DESCRIBES a training program in the problems of children for police, probation, and parole officers from the catchment area of the Massachusetts Mental Health Center. This area has a population of approximately 200,000 and consists of parts of the city of Boston and the adjacent town of Brookline. It is in a central section of a large city and has a heterogeneous population. There is a complete spectrum of socioeconomic conditions and ethnic subcultures.

The 30 training program participants represented ten different law enforcement agencies and included officers from two police forces; probation officers from four municipal courts, a superior court, and a juvenile court; and parole officers from both the adult and juvenile system. For convenience, this group will be referred to as "law enforcement officers."

The program, which was managed by the Division of Legal Medicine, Community Mental Health Services, Massachusetts Mental Health Center, was designed to focus on two issues bearing on the development of a law enforcement training program by a community mental health center. The first issue is the difficult relationship that exists between many law enforcement agencies and other social service and community organizations. The second issue is the pressure on individuals to perform duties in the style of the agency or system of which they are members. This paper gives the background and overview of our experience.

Dr. Rolde is Director, Dr. Fersch is a psychologist, and Ms. Frank is a social worker at the Legal Medicine Unit, Massachusetts Mental Health Center, Boston, Mass. Dr. Rolde is also Assistant Professor of Psychiatry, Harvard School of Medicine. Dr. Kelly is Professor of Education, Boston College, and Mr. Guberman is Assistant Chief Probation Officer, Norfolk County, Mass. Reprints may be obtained from Dr. Rolde at 27 Fields Pond Rd., Weston, Mass. 02193.

PAST PROBLEMS OF LAW ENFORCEMENT TRAINING PROGRAMS

Most law enforcement officers are given some training in the problems of children. The most common type of program is usually provided at the time of recruitment by a specific agency to its own staff. Arrangements made for individual officers to attend classes in academic institutions are increasingly common. Formal programs run for law enforcement agencies by outside groups are also common. Most often they are one of three types (1–9): didactic lectures or demonstrations, primarily for new recruits; sensitivity groups, most often led by a professional leader with law enforcement officers as group members; and training in special techniques for a subunit of the agency (e.g., training of special family intervention teams). We are not aware of any combined inservice training programs for police, probation, and parole officers.

Our contacts with social service agencies, consulting firms, and law enforcement officials revealed a consistent opinion that training programs run by outside organizations for law enforcement personnel, especially those run by mental health organizations, were of little value. Most people felt, however, that there was a pressing need for programs providing contact between law enforcement and other disciplines. Many papers in the literature also reflect this concern (10,11).

In the past, training programs have faced a fundamental difficulty: ignorance, mutual disrespect, and absence of communication between lawmen and social service personnel working with the same clients. Many mental health workers believed that law officers as a group knew very little about behavior, both their clients' and their own. It was often in a patronizing and pejorative manner that mental health workers implied that they could teach law officers more about behavior and make them better at their jobs. Since a major part of the law officer's job involves understanding his "client's" behavior and controlling his own behavior in a professional manner, the mental health worker often appeared to be telling him that he did not know how to do his job.

A second common difficulty reported primarily by those involved in training programs is the relationship of

the individual law officer to the system or agency of which he is a part. Those who felt they had overcome communication barriers and provided program participants with useful information often felt their work was undone because of the pressure on the individual officer to follow the behavior model of the agency. Several former faculty members of training programs said that their programs were useless: before individual officers could change their behavior, the law enforcement agency would have to change.

The problems of training for law enforcement officers are even further compounded by the diversity of the law enforcement system itself. There are major obstacles to the interaction and understanding of different components of the system. On the one hand, police, parole, and probation officers are often working in administrative isolation from and conceptual antagonism to one another. On the other hand, there are differences and barriers to cooperation between differing units of the same components. Differences in style among neighboring police departments are foremost among these.

CONCEPTUAL FOUNDATION OF THE PROGRAM

Our first premise was that the individuals who knew most about law enforcement work were the officers. This was especially true of our participants, most of whom had ten to 20 years of work experience in our geographic area. We believed that this group knew more than any other about the techniques and problems of handling a delinquent adolescent, for example. Consequently, we avoided telling the officer how to do his job; we felt that would be presumptuous and would most likely produce resistance and antagonism.

Our second premise was that a great deal of law enforcement work, especially that involving the maintenance of order, requires the officer to deal with community, family, and individual problems (12–18). Consequently, we assumed that it would benefit law officers to hear how other agencies and professions approach the same problems. They might find some of these other approaches useful in their work and it might also give them a clearer perspective on what their clients experience in the community. Finally, they would be introduced to other agencies and their staff and would be able to contact them and work with them in the future.

Two features of the program were designed for maximum behavior change, not only in the officers' work routine, but in their organizations as well. The first was relevance. There were no "outside speakers." All guests were members of local agencies. They discussed their agency's policies and problems and were able to take back to their agency the reaction of the other participants. The second feature was the length of the training program. Participants had a chance to develop trust in the staff and each other over time and to become comfortable in the discussion meetings. There was an opportunity for them to think about the presentations and continue to react to them over a long period. The extended time also allowed us to continually adjust the program to the pace and interests of the officers.

MECHANICS OF THE PROGRAM

The group of 30 officers met every other week for about one year. They received a stipend roughly equal to their regular pay. Each session lasted two to three hours. The first half of each session consisted of a presentation by representatives of a guest agency; questions and discussion came from the group as a whole. The second part consisted of meetings in small groups, which included both officers and guest agency staff. The project staff helped the guest agency prepare the presentation and moderated the meeting and the smaller group discussions.

The program focused on youth and the development of delinquency. We emphasized both social and psychological points of view. We chose guest agencies and organized the presentations so that there would be a coherent and orderly sequence. At the same time, we tried to raise the interest level and enthusiasm of both the individual guests and the officers. We wanted lively and relevant discussions of definite points of view, rather than comprehensive reviews of subject matter. Invited guests included staff members of local universities and public school systems; local judges and public defenders; youth, family, and drug treatment agencies; funding organizations; and law enforcement agencies.

At the end of every fifth meeting or so, there was a review session in which there were no invited guests. The sessions were used to digest, review, and complete previous topics, to evaluate what had already happened, to plan future programs, and to consider suggestions from the participants for presentation to other community agencies.

EXPERIENCE WITH THE PROGRAM

Obtaining the cooperation of the participating agencies was a major task. Permission for members to participate was obtained from the ten different law enforcement organizations and numerous guest agencies. The full participation of the different groups in the sessions was one of the major intermediate goals and accomplishments of the program.

Although the law enforcement agencies agreed to participate, they expressed a good deal of skepticism about the value of the program. The skepticism was supported, in most cases, by what individual officers reported as bad experiences with past training programs and with social service and mental health professionals. At the first session, attendance varied among the different law enforcement groups. The one agency that did not offer a stipend to its staff was fully represented. The agency that had enrolled the largest number in the program, a police department, had only two men present at the first session. At the second session, all of its representatives were present.

By the third session, additional men from that agency had asked to be included in the program. After the first two or three weeks, attendance at the sessions was close to complete for all the participating agencies.

PROGRAM SESSIONS

A sense of the structure and content of the program can best be conveyed by brief descriptions of several sessions.

The guests at one of the sessions were 30 grammar school principals, guidance counselors, and adjustment counselors from Brookline, Mass. The superintendent and staff of the department of education had expressed a great deal of interest in knowing more about the work of the law enforcement agencies and in working more closely with them. One of the guidance counselors raised the central issue confronting school personnel in cooperating with law officers. It was confidentiality, what they should do when a child comes to them and confides that he is breaking the law. The issue is complicated and raised many questions about the techniques used and roles assumed by school staff and law officers in their dealings with children.

During the second half of the session the participants broke into three smaller groups of about 20. There were equal numbers of school and law enforcement personnel in each. While the three discussions differed, a common theme appeared initially. The law enforcement officers tended to believe that the school staff were too lenient to be of help to children in many situations. The school personnel tended to believe that law enforcement officers would almost always be too severe. Soon both groups gave examples of how they wished to be more like the other. At the same time, both expressed fears of what would happen to their clients if the other group had its way. After the session both sides asked that we set up continuing sessions of this type in Brookline during the following years.

At another session, the guest speaker was the director of the state bureau that manages federal "safe streets" money. He discussed his bureau's policies and plans and mentioned in particular the problems it faces in funding programs for delinquent youth. The officers told him they had long felt that his agency had neglected to take advantage of their views and expertise and had never made it clear why certain decisions were made. The guest speaker explained the reasons for some controversial policies and asked the group's opinion on several issues that were under consideration at the time. The officers began to feel that they were being heard and some of the decisions were not reached as arbitrarily as they had thought, or that they at least understood the policies better. There was a noticeable increase in their morale and in their knowledge of program decisions and funding management.

Another of the meetings was held in the children's unit of the Massachusetts Mental Health Center. The law enforcement group met with several members of the staff including psychiatrists, psychologists, and social workers. The meeting began with a film on hyperactive children. After the film there was a presentation by one of the child psychiatrists and a general discussion of the film and presentation. The discussion centered on the way psychiatrists relate to children and on the hyperactive syndrome itself.

During the session and discussion period, the view each group held of the other began to emerge. The law enforcement officers felt that the mental health workers did not really know much about children who get into trouble with the law. They also felt that the doctors were not very warm in their dealings with children and tended to treat them as subjects rather than as persons. The mental health workers thought the officers were interested in law enforcement rather than people and felt that a law enforcement background did not prepare them for sophisticated concepts. This session was well received by most of the officers. They felt they had learned something useful about hyperactive children and gave this as an example of a subject the mental health workers knew something about and for which they had specific treatment methods that related directly to law enforcement work. Most important, however, was their feeling about a session with psychiatrists from the mental health center. Many commented on the doctors' willingness to listen to their points of view and said they felt much more comfortable about coming to the center when their work took them there.

RECEPTION OF THE PROGRAM

Several things indicated that the program was very favorably received by the law enforcement participants. The sessions themselves were enjoyable and the participants were enthusiastic. They often said they looked forward to the sessions and talked about them often with us and between themselves during the week. Attendance was very good throughout the duration of the program, even though the participants were busy and often had to make complicated arrangements to attend. Almost all the participants reported that the sessions were useful. This favorable response was made both in the discussion sessions and our formal evaluation interview and in subsequent reports to us.

Most important, there were numerous indications that the program changed the work behavior of the participants and influenced the practices of their agencies. Several instances were reported of improved working relationships between officers and agencies that had participated as guests in the program and between officers representing different departments or divisions within law enforcement agencies.

While this type of evidence does not constitute a controlled evaluation, it is still very encouraging. It is clear that we have learned a great deal about the problems and practices of law enforcement and have established relationships with individuals and organizations that would have been difficult to establish without the program.

While the focus of the training was on changing the behavior of the officers, the learning process obviously worked both ways. In fact, the sessions were most often a very challenging and useful experience for the invited guests. We hope to focus on this aspect of the program more fully in a later paper.

REFERENCES

1. Bard M, Berkowitz B: Training police as specialists in family crisis intervention: a community psychology action program. Community Ment Health J 3: 315–317, 1967
2. Elkins AN, Papanek GO: Consultation with the police: an example of community psychiatry practice. Am J Psychiatry 123:531–535, 1966
3. Friedman MH: Community mental health education with police. Ment Hyg 49:182–186, 1965
4. Lipsitt P: An experiment in police community relations: a small group approach. Community Ment Health J 5:172–179, 1969
5. Matthews RA, Rowland LWA: A Manual for the Police Officer: How to Recognize and Handle Abnormal People. New York, National Association for Mental Health, 1960
6. Lonkes GA: How should we educate the police? Journal of Criminal Law, Criminology, and Police Science 61:587–592, 1970
7. Siegel AI, Federman P, Schultz DG: Professional Police Human Relations Training. Springfield, Ill, Charles C Thomas, 1963
8. Sikes NP, Cleveland SE: Human relations training for police and community. Am Psychol 23:766–769, 1968
9. Watson NA: Human Relations Training for Police: A Syllabus. Washington, DC, International Association of Chiefs of Police, 1968
10. Germann AC: Changing the police: the impossible dream. Journal of Criminal Law, Criminology, and Police Science 62:416–421, 1971
11. Taylor EM, McEachern AW: Needs and directions in probation training. Federal Probation 30:18–24, 1966
12. Barton M: The Policeman in the Community. New York, Basic Books, 1965
13. Bittner E: Police discretion in emergency apprehension of mentally ill persons. Social Problems 14:278–292, 1967
14. Cummings E, Edell L, Cummings I: Policeman as philosopher, guide, and friend. Social Problems 12:276–286, 1965
15. Liberman R: Police as a community mental health resource. Community Ment Health J 5:111–120, 1969
16. MacNamara JH: Uncertainties in police work: the relevance of police recruits' background and training, in The Police: Six Sociological Essays. Edited by Bordua DJ. New York, John Wiley & Sons, 1967, pp 163–252
17. President's Commission on Law Enforcement and Administration of Justice: Task Force Report: Police. Washington, DC, US Government Printing Office, 1967
18. Wilson JQ: Varieties of Police Behavior. New York, Atheneum, 1970

The Manfred S. Guttmacher Award

The American Psychiatric Association invites applications for its annual Manfred S. Guttmacher Award for 1974. The award is given for any outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or any other work, including audiovisual presentations, submitted to or presented at any professional meeting or published during the year ending December 31, 1973. The award, which includes an honorarium of $250 and a plaque, will be presented at the Convocation of Fellows at the annual meeting in Detroit, Mich., May 1974.

Anyone who wishes may apply to receive the award by submitting five copies of the work as well as five abstracts to Jonas Rappeport, M.D., Chairman, Guttmacher Award Board, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Entries will be acknowledged but will not be returned.

The deadline for submissions is January 1, 1974, and any entry to be considered must be in Washington by that date.

The Use of Lithium in Affective Disorders, III: A Double-Blind Study of Prophylaxis in Bipolar Illness

BY FRANK STALLONE, PH. D., EDWARD SHELLEY, M.D., JULIEN MENDLEWICZ, M.D., AND RONALD R. FIEVE, M.D.

The authors studied 52 manic-depressive patients who were assigned to either lithium or placebo during their normal interval phases for periods up to 28 months. Patients receiving lithium had fewer manic and depressive episodes per patient-year than placebo patients. However, this difference may have been due to a sample bias produced by a large dropout rate among patients who had manic episodes. The findings also suggest a relationship between response to lithium and family history of bipolar illness.

THIS IS THE THIRD PART in a series of ongoing investigations concerning the use of lithium carbonate in the affective disorders. The first of the previous studies (1) was concerned with lithium in the treatment of depression, and the second (2) was a single-blind study of lithium in the prophylaxis of depression. Continuing this line of investigation, several controlled, double-blind studies on lithium prophylaxis in various subtypes of primary affective disorder are currently in progress. The present report is concerned with bipolar manic-depressive illness.

It has been hypothesized that when lithium is administered chronically to manic-depressive patients, it prevents a recurrence of future episodes of mania and depression or significantly lessens their severity and duration. This premise has been the subject of international controversy in the last several years. Since its introduction into psychiatry about 20 years ago, lithium therapy has been clearly established as a highly effective and specific treatment for acute manic attacks in many clinical trials in the United States and elsewhere. However, long-term chronic administration of lithium during symptom-free intervals for purposes of preventing subsequent attacks of the illness has been enthusiastically supported by some investigators and seriously questioned by others.

Revised version of a paper read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032, where Dr. Stallone is Associate Research Scientist; Dr. Shelley is Ward Administrator, Metabolic Research Unit; Dr. Mendlewicz is Visiting Research Fellow, Belgian American Education Foundation, Department of Medical Genetics; and Dr. Fieve is Chief of Psychiatric Research, Department of Internal Medicine and Metabolic Research Unit. Dr. Mendlewicz is also Senior Psychiatrist, Brugmann Psychiatric Hospital, Brussels, Belgium; and Dr. Fieve is also Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, New York, N.Y.

The authors wish to thank Dr. Joseph Fleiss for his advice on the statistical analysis and his consultation in preparing the manuscript and Ms. Geraldine Dalesandro and Mr. John O'Brien for their assistance in tabulating the data.

THE LITERATURE ON LITHIUM

The original claims for lithium prophylaxis stemmed from evidence gathered from either open clinical trials or studies in which inadequate controls were imposed. The most extensive of these early prophylactic studies was that reported by Baastrup and Schou (3). In that study patients were selected on the basis of the frequency of their episodes during the pretreatment, lithium-free pe-

Topical Papers is a new section of the Journal. *The papers in this section are grouped around a given topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.*

riod. The number of episodes during this period was then compared with the number of episodes that occurred during a subsequent lithium administration period of similar duration. The study of 88 patients in this research design revealed a remarkable reduction of affective episodes, both manic and depressive, during the lithium period as compared with the pretreatment period. The reduction in episodes was noted both in bipolar manic-depressive illness, in which a history of both manic and depressive episodes is present, and in unipolar depressive illness, in which there is no evidence of manic behavior in the patient's history. Baastrup and Schou concluded that the administration of lithium was responsible for the prevention of episodes that would otherwise have occurred.

Blackwell and Shepherd (4) and others have criticized Baastrup and Schou on the grounds that their conclusions are unwarranted because of a fallacy in their research design. The comparison of the frequency of episodes in the pretreatment period with the frequency in the treatment period is predicated on the assumption that the frequency of episodes in the pretreatment period can be used as an index to the frequency in any subsequent period of similar length. However, since manic-depressive illness is characterized by episodes that occur in an unpredictable, random manner, this assumption is invalid. If the occurrence of episodes is indeed random, then the selection of a pretreatment time interval that had a relatively large number of episodes is likely to be followed by a period of fewer episodes. Thus the lithium administration period was, by virtue of research design, likely to be a period of remission.

This criticism was supported, in a study by Saran, by reference to the longitudinal course of the illness in cases of manic-depressive disease not treated with lithium (5). In the latter study it was shown that time intervals in which a relatively large number of episodes occurred were followed by time intervals of equal duration in which significantly smaller numbers of episodes occurred. Saran argued that, since this phenomenon is characteristic of the natural course of the illness, the reduction in the number of episodes in the intervals following those intervals during which a large number of episodes occurred cannot be attributed to lithium prophylaxis.

The resolution of this controversy rests with carefully designed double-blind controlled studies, several of which have been reported recently. Baastrup and associates (6) have themselves conducted a double-blind study in which matched pairs of patients were assigned at random to either lithium or placebo groups and were followed closely. After five months the study was discontinued when 21 of the patients in the placebo group and none of the patients in the lithium group developed episodes. Evidence of lithium prophylaxis was found in the prevention of manic and depressive episodes in bipolar manic-depressive patients and in the prevention of depressive episodes in unipolar endogenous depressive patients.

Melia (7) has reported a double-blind study in which 18 manic-depressive patients were randomly assigned to either lithium or placebo during the normothymic state. He found that the mean period of remission in the lithium group (433 days) was nearly twice as long as that in the placebo group (244 days).

Further evidence of lithium prophylaxis is provided in a British collaborative study reported by Coppen and associates (8). Sixty-five patients, both bipolar manic-depressives and unipolar recurrent depressives, were randomly assigned to either lithium or placebo treatments and were followed closely for up to 112 weeks. The results were clearly in support of lithium prophylaxis in terms of several criteria, including the number of episodes, ratings of severity of episodes, and amounts of antidepressant and antimanic medication when these were needed. Lithium was found to be equally effective in the prevention of manic and depressive episodes in bipolar illness and in the prevention of depressive episodes in unipolar illness.

In contrast to the previously cited studies, Stancer and associates (9) studied lithium prophylaxis in open trials with 21 manic-depressive patients. They concluded, "Our clinical trials do not support the notion that lithium is a prophylactic agent against recurrent depressions. . . ."

Studies on the treatment of acute mania have clearly shown that lithium is an effective antimanic agent. It seems reasonable to predict, therefore, that lithium would be effective in preventing mania. However, the picture is not so clear in the case of depression. Although mild antidepressant effects have been reported in double-blind trials comparing lithium with imipramine (1), lithium is not generally used as a clinically effective drug in the treatment of depression. Furthermore, a recent study has shown that mild antidepressant response to lithium is confined to patients with bipolar illness and does not occur in patients with unipolar depression (10).

In view of these findings, the question of lithium prophylaxis needs to be more fully investigated, with particular attention to comparisons between depressive subtypes. The present study is part of a large, long-term lithium prophylaxis project that is still in progress. The focus of this report will be a double-blind controlled investigation of lithium prophylaxis in manic-depressive bipolar illness.

METHOD

Selection of Patients

To be included in the study patients had to be diagnosed independently by two psychiatrists as having bipolar manic-depressive illness. Patients were selected only if they had a history of at least three episodes of affective disorder with intervals of normal functioning between episodes. At least one of these episodes had to be a manic episode, in which the patient became overactive and overtalkative, had reduced need for sleep, became grandiose in his planning, and became sexually hyperactive. Depressive episodes were variously characterized by depressed and tearful mood, lack of appetite and weight loss, sleep disturbance, loss of energy, low self-esteem, anxiety, and agitation. Each episode had to be of at least two weeks' duration and of sufficient sever-

TABLE 1
Mean Age and Sex Distribution of Patients

Group	N	Age (Mean ± SD)
Lithium		
Men	12	54.75 ± 11.10
Women	13	49.46 ± 10.45
Placebo		
Men	13	48.15 ± 15.40
Women	14	50.79 ± 9.78

ity to impair the patient's usual functioning. Schizoaffective patients were excluded from the study.

In order to maintain comparability with the selection criteria adopted by Baastrup and Schou (3), patients were included in the study only if at least two episodes had occurred within the two years prior to entrance into the trial.

Regimen and Research Plan

At the time of inclusion into the study, all patients were symptom free and were not being treated with antidepressant or tranquilizing medications. Some, however, had been receiving lithium openly as a prophylactic drug at the time they entered the study.

All patients were randomly assigned on a 50-50 basis to either the lithium or the placebo treatment group. During the first week of study the dosage was gradually built up to three white, opaque capsules per day. Each capsule for patients in the lithium group contained 300 mg. of lithium carbonate. Identical white capsules of placebo were used in the placebo group. In the case of patients who had been receiving lithium prior to their inclusion in the study, their previous schedule of white capsules was continued.

Assignments to lithium and placebo groups were made on a double-blind basis. Neither the psychiatrists who treated the patients nor the nursing teams who rated the patients were informed of the patients' assignments. After the initial administration of the drug, serum levels were monitored once every four weeks and dosages were regulated so as to maintain a serum lithium level of 0.8 to 1.3 mEq./liter. The psychiatrists who regulated the drug dosage were given fictitious serum levels for the placebo patients in order to prevent their detecting which patients were receiving placebo.

Each study patient visited the clinic once every four weeks and was interviewed by a psychiatric nursing team and rated for mania and depression on a special scale devised for the purpose. The scale records the severity of each of 18 depression symptoms and each of 13 manic symptoms. If a patient was judged sufficiently ill to require additional medication, he was considered a failure. During the failure, experimental medication was continued and additional medication was introduced to treat the episode. The treating psychiatrist was unaware of the experimental medication being used. Either amitriptyline or imipramine was used as additional medication in the treatment of depression, and chlorpromazine was used to treat mania. Every effort was made to continue the patient in the study during the episode. The intent was to treat the episode as vigorously as possible with the best available standard medications while the patient continued to receive white capsules. After the episodes were over, the patients continued in the study, receiving only white capsules, until they completed a trial of 24 months. The advantage of this design is that both the frequency and duration of episodes could be compared in the lithium and placebo groups. As will be pointed out later, however, it was not possible to adhere to this research design in many cases.

The research plan was implemented in October 1969. From then until January 1970, 36 patients were started on the study. Sixteen more were subsequently added. Although the study is still in progress, for purposes of this report the data up to February 1972 were analyzed. Therefore lithium prophylaxis for periods up to 28 months is assessed in this report.

Family History of Study Patients

All the available first-degree relatives and the spouses of the patients accepted in this study were examined in order to determine the presence of psychopathology in their families. The relationship between family history of manic-depressive illness and response to lithium prophylaxis will be discussed later.

RESULTS

The mean ages and sex distribution of the patients are given in table 1. The mean age in each group was approximately 50 years. Patients' ages ranged widely, from one in his early twenties to several in their late sixties and early seventies. No appreciable differences in age or in sex distribution were noted between the lithium and placebo groups.

If lithium exerts a prophylactic effect on manic-depressive illness, those patients assigned to the lithium group would be expected to remain in remission longer

TABLE 2
Number of Months in Remission from Time of Entrance Into Study to Time of First Episode

Number of Months	Lithium Group (N=25)	Placebo Group (N=27)
25–28	14	2
19–24	1	1
13–18	0	0
7–12	4	3
1–6	6	21
Mean ± SD*	17.88 ± 10.47	6.33 ± 7.21

*T ratio for difference between means is 4.66, d.f. = 50, $p < .001$.

TABLE 3
Reasons for Dropping Out

Reason	Lithium Group (N=25)	Placebo Group (N=27)
Patient pressed for open treatment after having an acute episode.	2	14
Patient ended participation in study during an acute manic episode and was hospitalized elsewhere.	1	4
Patient withdrew from study in order to undergo a different treatment plan.	4	2
Patient dropped out for reasons unrelated to manic-depressive illness (e.g., physical illness, moved out of the area).	2	2
Total	9	22

than those assigned to the placebo group. Table 2 shows the number of months patients remained in remission from the time of entry into the study to the time of the first episode. Fourteen of the 25 lithium patients remained in remission for over two years (up to February 1972, or 25 to 28 months). Only two of the placebo patients remained in remission for the full time. The mean number of months in remission was nearly three times as great in the lithium group (17.88) as in the placebo group (6.33). The difference between these means is statistically significant ($p<.001$).

At the end of the time interval with which this report is concerned (February 1972), 31 of the original 52 patients had dropped out of the study. The reasons for dropping out are given in table 3. Twenty-two of the 31 dropouts were in the placebo group. Eighteen of these dropouts were directly attributable to the disruptive effects of an acute episode, usually manic. Only three lithium patients dropped out because of an acute episode of illness. It is clear that the placebo patients' proneness to acute episodes made it impossible for them to remain in the study on placebo for the 24 months, as was originally intended.

Because of the more rapid dropout rate in the placebo group, the two groups were not studied for equal durations. The lithium patients were in the study for a mean of 1.840 years and the placebo patients for a mean of 0.685 years. Comparisons of the mean number of episodes in the two groups, therefore, had to control for this difference in study time. This was done by computing the mean number of episodes per patient-year, shown in table 4. Without controlling for study time, the mean numbers of manic episodes in the lithium and placebo groups were 0.200 and 0.593, respectively. However, controlling for study time, the mean numbers of manic episodes per patient-year in the lithium and placebo groups were 0.109 and 0.865, respectively.

The evaluation of the significance of the difference between the mean numbers of episodes per patient-year is by means of the critical ratio of the difference to its standard error (11). The ratio for the comparison of the mean number of manic episodes per patient-year in the lithium and placebo groups was 8.968, which is statistically significant ($p<.005$).

Similar comparisons between lithium and placebo groups for the number of depressive episodes are also shown in table 4. Comparisons of the mean number of depressive episodes without controlling for study time revealed a very small difference—means of 0.440 and 0.481 episodes in the lithium and placebo groups, respectively. However, when controlling for study time, the mean numbers of depressive episodes per patient-year in the lithium and placebo groups were 0.239 and 0.703, respectively. This difference yielded a critical ratio of 6.48, which is statistically significant ($p<.025$).

Ratings of severity of depression were done by means of a rating scale completed by the nurses during the monthly patient interviews. The scale rated the severity of 18 symptoms of depressive pathology: mood, sleep disturbance, difficulties in daily functioning, motor retardation, agitation, suicidal ideation, difficulties in concentration, hostility, low self-esteem, pessimism, hyposexuality, hypochondriasis, social withdrawal, indecisiveness, anxiety, guilt, personal appearance, and appetite disturbance. Total scores were used as an index of overall severity of pathology. The maximum total scores of the depressed patients in both groups were compared in order to determine, in cases where lithium did not prevent a depressive episode, whether it tended to moderate or dampen its severity. The mean maximum total scores of the depressed patients in the lithium and placebo groups were 28.50 and 26.32, respectively. The difference between these means was not statistically significant. Therefore those patients who became depressed while receiving lithium did not, as a group, have less severe depressions than the depressed patients in the placebo group, when measured in terms of their ratings.

However, the hospitalization rates of the depressed patients in the lithium and placebo groups are of interest. The decision of whether or not to hospitalize a patient was made by a physician who was unaware of the patient's particular treatment. Of the 13 placebo patients who became depressed, seven (53.8 percent) were hospitalized. In contrast, only two of the seven lithium patients who became depressed (28.6 percent) were hospitalized. Two additional lithium patients were hospitalized for de-

TABLE 4
Comparisons of Frequency of Manic and Depressive Episodes in Lithium and Placebo Groups

Item	Lithium Group (N=25)	Placebo Group (N=27)
Mean number of years in study	1.840	0.685
Mean number of manic episodes	0.200	0.593
Mean number of manic episodes per patient-year	0.109	0.865
Mean number of depressive episodes	0.440	0.481
Mean number of depressive episodes per patient-year	0.239	0.703

TABLE 5
Relationship Between Response to Lithium and Family History of Mania

Family History of Mania	Lithium Responders	Lithium Nonresponders
Positive	11	1
Negative	6	7

pression, but they had both discontinued taking lithium shortly before being hospitalized. One of them attempted suicide three days after discontinuing lithium. The other one went into an acute depressive stupor. These findings are not statistically significant and need to be interpreted with caution. However, they suggest that depressed patients receiving placebo are more prone to acute episodes requiring hospitalization than are those on lithium, who, although significantly depressed, can be treated as outpatients.

The isolation of a group of patients who do not respond to lithium raises the question of the relationship between response to lithium and classification of depressive subtypes. Table 5 shows the distribution of lithium responders and nonresponders in relationship to the presence or absence of mania in the probands' first-degree relatives. Although the numbers are small and need to be confirmed by a larger series, lithium responders seem to be more likely to have a family history of mania than nonresponders. Fisher's Exact Probability Test was applied to the data in table 5 and showed that the distributions would have occurred by chance less than two percent of the time.

DISCUSSION

The present research findings clearly establish the effectiveness of lithium in the prophylaxis of mania and also tend to support the use of lithium in the prophylaxis of bipolar depression. These findings are consistent with those reported by previous investigators (6–8), and they also confirm a previous single-blind prophylaxis study done at our clinic (2).

The findings with respect to lithium in the prophylaxis of depression are ambiguous. Since a large proportion of placebo patients experienced acute manic episodes, it was not possible to continue them in the study in order to evaluate the effectiveness of lithium in the prophylaxis of depression. Therefore comparisons of the rate of failures due to depressive episodes between lithium and placebo groups did not include the large proportion of placebo patients who had dropped out because of severe manic episodes. A further clarification of whether lithium is effective in the prophylaxis of depression requires comparisons between lithium and placebo groups that are studied for approximately equal durations. Further studies are currently under way with patients who are not prone to acute manic episodes and who are, therefore, more likely to complete lengthy trials without dropping out.

The finding that lithium response is related to the presence of mania in the family is consistent with a recent report by Mendlewicz and associates (12), which showed that manic-depressive patients with a strong genetic background of this disorder tend to have more severe episodes. Patients with a family history positive for this disorder may represent a special subgroup of manic-depressive illness. The present genetic finding underscores the need to relate response to lithium therapy to subtypes of depressive illness. Toward this end, we are currently engaged in studies of lithium prophylaxis of unipolar depression and chronic depressive illness.

REFERENCES

1. Fieve RR, Platman SR, Plutchik RR: The use of lithium in affective disorders, I: acute endogenous depression. Am J Psychiatry 125:487–491, 1968
2. Fieve RR, Platman SR, Plutchik RR: The use of lithium in affective disorders, II: prophylaxis of depression in chronic recurrent affective disorder. Am J Psychiatry 125:492–498, 1968
3. Baastrup PC, Schou M: Lithium as a prophylactic agent: its effects against recurrent depression and manic-depressive psychosis. Arch Gen Psychiatry 16:162–172, 1967
4. Blackwell B, Shepherd M: Prophylactic lithium: another therapeutic myth? Lancet 1:968–971, 1968
5. Saran BM: Lithium. Lancet 1:1208–1209, 1969
6. Baastrup PC, Poulsen JC, Schou M, et al: Prophylactic lithium: double-blind discontinuation in manic-depressive and recurrent depressive disorders. Lancet 2:326–330, 1970
7. Melia PI: Prophylactic lithium: a double-blind trial in recurrent affective disorders. Br J Psychiatry 116:621–624, 1970
8. Coppen A, Noguera R, Baily J, et al: Prophylactic lithium in affective disorders: controlled trial. Lancet 2:275–279, 1971
9. Stancer HC, Furlong F, Godse DD: A longitudinal investigation of lithium as a prophylactic agent for recurrent depressions. Can Psychiatr Assoc J 15:29–40, 1970
10. Goodwin FK, Murphy DL, Bunney WE: Lithium carbonate treatment in depression and mania. Arch Gen Psychiatry 21:486–496, 1969
11. Deming WE: Some Theory of Sampling. New York, Dover Publications, 1966, p 177
12. Mendlewicz J, Fieve RR, Rainer JD, et al: Manic-depressive illness: a comparative study of patients with and without a family history. Br J Psychiatry 120:523–530, 1972

Relationship Between the Effectiveness of Lithium Therapy and Family History

BY JULIEN MENDLEWICZ, M.D., RONALD R. FIEVE, M.D., AND FRANK STALLONE, PH.D.

As part of a continuing study, 72 manic-depressive patients were randomly assigned to treatment with either lithium carbonate or placebo. Of these, 67 percent were treated successfully and 33 percent were long-term failures. Data that reflected the incidence of psychopathology in the first- and second-degree relatives of the patients were collected. Striking differences were observed in the backgrounds of lithium responders and failures: response to lithium treatment was significantly associated with the presence of manic-depressive illness in the patients' families.

MOUNTING EVIDENCE for the long-term stabilizing properties of lithium in bipolar manic-depressive illness is found in several controlled longitudinal studies (1–5). Although the time periods during which the patients were studied are not always comparable in these reports and criticisms of design have been made (6–8), the long-term response rate of bipolar manic-depressive patients receiving lithium seems consistently superior to that of patients on placebo. Despite this, failures still occur. If lithium indeed possesses true psychotropic properties, several factors might account for a patient's failure to respond to lithium treatment.

First, to obtain a full tissue effect, the serum lithium level should usually be maintained between 0.8 and 1.3 mEq./liter, but this may vary with age and other variables not yet studied. Fry and Marks (9) have shown that 18 percent of 100 unselected patients receiving lithium had a lithium plasma level below 0.6 mEq./liter. These low serum levels were said to be due to too low a level of lithium dosage or to the patients' failure to take the tablets.

In addition to the possibility of placebo response, which will not be discussed in this paper, the variability of response to lithium might be due to differences in the metabolism of lithium among patients with affective disorders. Serry (10) has studied the urinary excretion of lithium by manic patients after a loading dose of lithium carbonate. Patients who had a pattern of slow urinary excretion of lithium tended to respond favorably to lithium treatment, while the ones who had a pattern of rapid excretion did not respond to the drug. Cade (11) also indicated that lithium retention might be a predictor for response to lithium treatment. Stokes and his colleagues (12), however, were unable to confirm these results.

The identification of a group of manic-depressive patients who do not respond to lithium, perhaps for biological reasons, raises the further possibility that these patients might be genetically different from those who are lithium responders.

METHOD

To investigate this hypothesis, we have undertaken a family study of all patients admitted into our continuing double-blind study of lithium therapy for bipolar illness. All the available first-degree relatives and spouses of the patients accepted into the study have been personally examined by one of the authors (J.M.), using scales designed to measure both current and past psychopathology (13) to determine the presence of psychopathology in their families.

Bipolar depression was diagnosed in probands and relatives who had a history of clear-cut manic behavior and of depressive episodes severe enough to require treatment or hospitalization or to cause a disruption in everyday activities for at least three weeks. Recurrence of illness with symptom-free intervals was one of the criteria used for the diagnosis of bipolar illness. Unipolar depression was diagnosed in individuals who had never experienced mania or hypomania but had experienced one or more depressive episodes severe enough to require treatment or hospitalization. For patients with either bipolar or unipolar illness, there had to be no personality disintegration before or after the psychotic episodes and no other preexisting psychiatric or medical disease that might produce symptoms that could be confused with those of affective disorder.

The investigator of family history (J.M.) was blind to which probands were assigned to lithium and which to placebo and to the patients' treatment response. The methods used for our family history study have been discussed in detail elsewhere (14). The research plan was implemented in October 1969. Although this double-blind

Read at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

The authors are with the New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032, where Dr. Mendlewicz is Visiting Research Fellow, Belgian American Education Foundation, Department of Medical Genetics; Dr. Fieve is Chief of Psychiatric Research, Department of Internal Medicine and Metabolic Research Unit; and Dr. Stallone is Associate Research Scientist. Dr. Mendlewicz is also Senior Psychiatrist, Brugmann Psychiatric Hospital, Brussels, Belgium; and Dr. Fieve is also Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, New York, N.Y.

The authors wish to thank Ms. Mima Cataldo for her research assistance and Prof. John D. Rainer for his review of the manuscript.

TABLE 1
Incidence of Affective Illness in First-Degree Relatives of Responder and Nonresponder Patients

Category	Patients Receiving Lithium			Patients Receiving Placebo		
	Responders	Nonresponders	Total	Responders	Nonresponders	Total
Bipolar illness in family	15	2	17	3	15	18
No bipolar illness in family	9	10	19	6	12	18
Total	24	12	36	9	27	36
Unipolar illness in family	18	9	27	6	19	25
No unipolar illness in family	6	3	9	3	8	11
Total	24	12	36	9	27	36

study of lithium therapy is still in progress, only the data for the first 37 months were analyzed for this report. All patients accepted into the study had previously experienced both mania and depression.

Forty-three patients were randomly assigned to lithium carbonate and 44 to placebo. After the initial administration of the drug, serum levels were monitored once every four weeks and dosage was regulated to maintain a serum lithium level between 0.8 mEq./liter and 1.3 mEq./liter. If a patient was judged by at least two independent blind evaluators to be ill enough to require additional medication (other than lithium) or hospitalization, he was considered a failure. Details on the method and clinical results of this double-blind study of lithium therapy are presented elsewhere (5).

RESULTS

In the lithium group (N=43), five patients were not normothymic (i.e., they showed evidence of either mania or depression) at the time of randomization, one dropped out of the study after two weeks, and one more patient was discontinued for medical reasons. In the placebo group (N=44), four patients were not normothymic at the time of randomization, three patients dropped out of the study within two weeks, and one patient was discontinued for medical reasons. These patients, seven in the lithium group and eight in the placebo group, have been disregarded in our analysis, because the evaluation of therapeutic outcome in this study requires a patient to be normothymic at the time of randomization and to be followed for at least six months in the study.

Of the 36 remaining manic-depressive patients followed on lithium carbonate, 24 (67 percent) were responders and 12 (33 percent) were long-term failures. Four of the 12 failures experienced manic episodes only, five experienced depressive episodes only, and three experienced both kinds of episodes. The lithium plasma levels for the responders as well as the failures were regularly maintained between 0.8 and 1.3 mEq./liter. Of the 36 patients followed on placebo, nine (25 percent) were responders and 27 (75 percent) were long-term failures. Thirteen of the 27 failures experienced manic episodes only, seven experienced depressive episodes only, and seven experienced both kinds of episodes. All patients taking placebo—responders as well as failures—were given fictitious lithium plasma levels between 0.8 and 1.3 mEq./liter to help maintain the blindness of the treating physician.

Four samples of patients were thus available for further analysis: responders and failures under lithium and responders and failures under placebo. The mean numbers of living first-degree relatives were similar in all four samples (range: 4.7 to 5.4 per family). The mean numbers of relatives examined were also similar (range: 3.7 to 4.4 per family). The age distributions of first-degree relatives in the lithium and placebo groups were comparable.

Table 1 compares the responders and nonresponders to lithium with respect to the presence or absence of bipolar and unipolar illness in the proband's first-degree relatives: 15 out of 24 responders to lithium had a positive family history of bipolar illness while only two out of the 12 nonresponders had a positive family history (χ^2 = 5.04, d.f. = 1, $.02<p<.05$).[1] However, 18 lithium responders had a positive family history of unipolar illness, compared with nine patients in the nonresponder group (χ^2 = 0.0, d.f. = 1, n.s.).

Because this association between family history of bipolar illness and response to treatment may reflect a lower frequency of affective episodes in patients with a positive family history of bipolar illness, irrespective of treatment, the association was examined separately for the placebo sample. Table 1 also shows an absence of any association between family history and "response to placebo" (χ^2 = 0.58, d.f. = 1, n.s. for bipolar illness; χ^2 = 0.05, d.f. = 1, n.s. for unipolar illness).

Information about second-degree relatives was obtained through the recollections of the interviewed subjects. When this information is taken into account, the association between a positive family history and lithium response becomes even stronger in the lithium sample (table 2). Nineteen out of the 24 responders to lithium had at least one first- or second-degree relative with

[1] Chi square with Yates' correction for small numbers is used throughout.

TABLE 2
Incidence of Affective Illness in First- and Second-Degree Relatives of Responder and Nonresponder Patients

Category	Patients Receiving Lithium			Patients Receiving Placebo		
	Responders	Nonresponders	Total	Responders	Nonresponders	Total
Bipolar illness in family	19	2	21	3	19	22
No bipolar illness in family	5	10	15	6	8	14
Total	24	12	36	9	27	36
Unipolar illness in family	19	9	28	7	20	27
No unipolar illness in family	5	3	8	2	7	9
Total	24	12	36	9	27	36

bipolar illness, while again only two of the 12 nonresponders to lithium had a positive family history (χ^2 = 10.42, d.f. = 1, .001 <p<.01). There was still no association between a positive family history of unipolar illness and response to lithium (χ^2 = 0.082, d.f. = 1, n.s.). Table 2 also shows that there was no corresponding association in the placebo sample even when second-degree relatives were taken into account (χ^2 = 1.31, d.f. = 1, n.s. for bipolar illness; χ^2 = 0.04, d.f. = 1, n.s. for unipolar illness).

DISCUSSION

Bipolar lithium responders are thus far more likely to have a family history of bipolar illness than are lithium nonresponders. Lithium response, however, does not show a correlation with the presence of unipolar illness in these families.

Although our results show a statistical association between lithium response and a family history of mania, it would be incorrect to conclude that all bipolar patients whose relatives do not have bipolar illness will not show a response to lithium. As a matter of fact, five such patients out of 15 (33 percent) are long-term lithium responders (table 2).

It is also difficult to discriminate between environmental and genetic factors in family studies, i.e., the association found between a favorable treatment response and a positive family history may well reflect certain environmental variables. For example, it is conceivable that patients with a family history of mania may know from the experience of other relatives the consequences of the manic condition and may be pressured into seeking treatment by their families. In contrast, patients with no family history of mania would not be subject to these pressures because the condition of mania and its consequences would be relatively unknown to the family. Whether or not these social factors play a role in the patients' treatment response will be the subject of future investigations.

In recent studies of bipolar illness, we have shown that patients with a positive family history of bipolar illness run a more severe course of illness and exhibit more mania than patients with no family history (14). Our data also suggest the presence of major gene inheritance in bipolar patients with a positive family history (15).

Although the numbers in this study are small and the results need to be confirmed by other investigators in controlled longitudinal studies in which serum lithium levels are monitored on a regular basis, these findings underscore the need for correlating a patient's response to lithium with his family background in order to predict the long-term response of patients on lithium maintenance therapy.

REFERENCES

1. Fieve RR, Platman SR, Plutchik R: The use of lithium in affective disorders, II: prophylaxis of depression in chronic recurrent affective disorder. Am J Psychiatry 125:492–498, 1968
2. Baastrup PC, Poulsen JC, Schou M, et al: Prophylactic lithium: double-blind discontinuation in manic-depressive and recurrent depressive disorders. Lancet 2:326–330, 1970
3. Melia PI: Prophylactic lithium: a double-blind trial in recurrent affective disorders. Br J Psychiatry 116:621–624, 1970
4. Coppen A, Noguera R, Bailey J, et al: Prophylactic lithium in affective disorders: controlled trial. Lancet 2:275–279, 1971
5. Stallone F, Shelley E, Mendlewicz J, et al: The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness. Am J Psychiatry 130:1006–1010, 1973
6. Blackwell B, Shepherd M: Prophylactic lithium: another therapeutic myth? Lancet 1:968–971, 1968
7. Lader M: Prophylactic lithium? Lancet 2:103, 1968
8. Lithium (editorial). Lancet 1:709–710, 1969
9. Fry DE, Marks V: Value of plasma-lithium monitoring. Lancet 1:886–888, 1971
10. Serry M: Lithium retention and response. Lancet 1:1267–1268, 1969
11. Cade JFJ: Lithium: historical perspectives and present status (abstract), in Scientific Proceedings in Summary Form: The 123rd Annual Meeting of the APA, San Francisco, Calif, May 11–15, 1970. Washington, DC, American Psychiatric Association, 1970, p 155
12. Stokes JW, Mendels J, Secunda SK, et al: Lithium excretion and therapeutic response. J Nerv Ment Dis 154:43–48, 1972
13. Endicott J, Spitzer RL: Current and past psychopathology scales: rationale, reliability, and validity. Arch Gen Psychiatry 27:678–687, 1972
14. Mendlewicz J, Fieve RR, Rainer JD, et al: Manic-depressive illness: a comparative study of patients with and without a family history. Br J Psychiatry 120:523–530, 1972
15. Mendlewicz J, Fieve RR, Rainer JD, et al: Affective disorder on paternal and maternal sides: observations in bipolar (manic-depressive) patients with and without a family history. Br J Psychiatry 122:31–34, 1973

Lithium-Induced Diabetes Insipidus: Manic Symptoms, Brain and Electrolyte Correlates, and Chlorothiazide Treatment

BY STEVEN T. LEVY, M.D., JOHN N. FORREST, JR., M.D., AND GEORGE R. HENINGER, M.D.

A patient with lithium-induced, vasopressin-insensitive diabetes insipidus was studied during two consecutive manic episodes that were successfully treated with lithium. Polyuria occurred several days after lithium-induced brain electrical changes were observed, and at serum lithium concentrations close to 1.0 mEq./liter. Polyuria began during a period of behavioral improvement and persisted after the manic symptoms subsided. Polyuria did not occur in association with serum lithium concentrations over 1.8 mEq./liter, and a fourfold increase in sodium intake did not reduce the polyuria. Chlorothiazide reduced polyuria and permitted the patient to continue the lithium treatment.

LITHIUM IS AN EFFECTIVE AGENT for controlling manic excitement (1, 2); there is evidence that it also prevents recurring manic and depressive attacks (3). It must be used with caution, however, because of its low therapeutic index with unwanted side effects often occurring at or below the effective dosage level. Among the more serious side effects is a diabetes insipidus-like syndrome that has been described by several authors (4–8). With the exception of one case (4), all of the patients who developed this syndrome failed to respond to exogenous vasopressin, a fact that indicates that there is a nephrogenic basis for the renal concentrating defect.

In the following clinical case study, it was possible to evaluate in a detailed longitudinal manner several factors that have not been studied in relation to lithium-induced diabetes insipidus and that might clarify our understanding of the development, course, and treatment of this serious side effect. These factors included changes in manic symptoms; the effects of lithium on the brain, as measured by changes in somatosensory cortical evoked responses; lithium and sodium balance, both of which were manipulated during the study; and renal concentrating ability. Because the patient's manic behavior was reduced by lithium treatment despite severe polyuria, lithium therapy was continued and the use of chlorothiazide in the treatment of diabetes insipidus was investigated.

Dr. Levy is Mental Health Career Development Officer, Adult Psychiatry Branch, Psychiatric Assessment Section, National Institute of Mental Health, Building 10, NIH, 9000 Rockville Pike, Bethesda, Md. 20014. Dr. Forrest is Assistant Professor, Renal Section, Department of Medicine, and Dr. Heninger is Associate Professor, Department of Psychiatry, Yale School of Medicine, New Haven, Conn.

This work was supported in part by Public Health Service grants MH-18949 and MH-50245 from the National Institute of Mental Health.

The authors wish to thank the nursing staff of the research unit of the Connecticut Mental Health Center, who helped collect the data.

CASE REPORT

The patient, a 54-year-old Caucasian woman with previous psychotic episodes and diagnosed as having manic-depressive psychosis, manic-type, was admitted to the research unit of a university-affiliated mental health center. The temperature and humidity of this research unit were controlled. Her first manic episode occurred when she was 31 and she had had a total of 12 episodes requiring psychiatric care. At the time of this study, the patient had been taking lithium carbonate for 18 months. Dosages ranged from 900 to 1500 mg. per day. Her serum lithium levels ranged from 0.8 to 2.1 mEq./liter. She periodically complained of polyuria during this time. Three weeks before her admission, the patient reported slurring of speech, tremor, fatigue, and difficulty in concentrating. Her lithium level was 2.1 mEq./liter. Because there were signs of lithium toxicity, her dosage was decreased from 1500 to 900 mg. per day. One week before her admission, her dosage was increased to 1200 mg. per day because of the appearance of hypomanic symptoms. At the time of her admission, the patient was talkative, hyperactive, markedly irritable, and verbally abusive. The results of laboratory tests at the time of admission—including serum sodium, potassium, chloride, bicarbonate, glucose, blood urea nitrogen, amylase, alkaline phosphatase, thymol turbidity, cephalin flocculation, bilirubin, uric acid, and protein bound iodine—were within normal limits. Her serum lithium level was 1.7 mEq./liter.

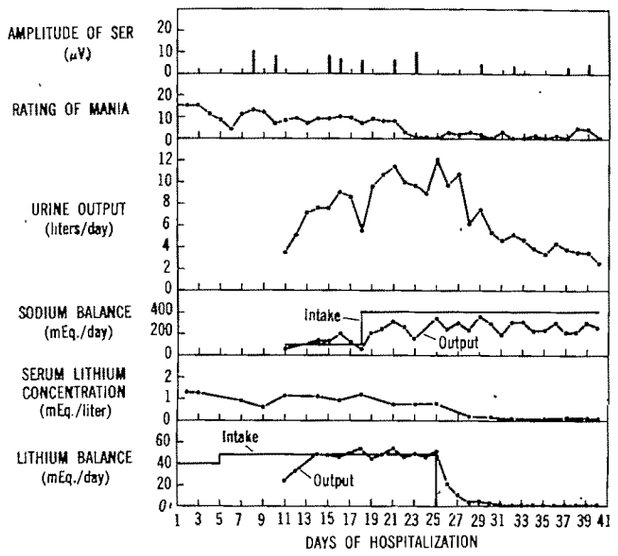
Serial studies of water and electrolyte metabolism and brain electrophysiology (see figures 1 and 2) were carried out during the following periods of the patient's hospitalization: 1) days one through 25—lithium therapy, with improvement of manic symptoms and development of polyuria; 2) days 25 through 45—placebo period, during which polyuria improved and manic symptoms reappeared; and 3) days 45 through 87—reinstitution of lithium therapy, with improvement of manic symptoms and reappearance of polyuria.

The patient was then discharged but continued lithium therapy; her polyuria was treated with chlorothiazide.

METHOD

While the patient was in the research unit, her serum lithium, sodium, potassium, chloride, bicarbonate, and creatinine levels were determined from venous blood samples drawn each Monday, Wednesday, and Friday at

FIGURE 1
Recovery from Manic Episode and Development of Lithium-Induced Polyuria (First 40 Days of Hospitalization)



8 a.m. Daily 24-hour urine collections were monitored for volume and for sodium, lithium, and creatinine content. Blood and urine chemical analyses were performed by the clinical chemistry and renal laboratories at Yale-New Haven Hospital. Lithium levels were determined by atomic absorption spectrophotometry.

Somatosensory cortical evoked responses (SERs) were studied at intervals throughout the study. Half-hour recording sessions took place between 10 a.m. and 2 p.m., during which the patient sat awake with her eyes closed in a dimly lighted, sound-attenuated chamber and was observed by closed-circuit television.

Each SER was the average potential difference between a silver disk electrode applied with collodin at C_3 (a location overlying the somatosensory area contralateral to the stimuli) and a similar electrode at F_3 (approximately 7 cm. anterior to C_3). The stimuli that produced the cortical evoked response were 64 constant-current 0.5 millisecond shocks delivered percutaneously every two seconds to the right median nerve at the wrist. The current delivered was just above the threshold for thumb twitching. Three SERs were obtained during each recording session and these were averaged to give one overall SER. The peak-to-peak amplitude of the potential with a negative peak at 19 milliseconds and a positive peak at 24–30 milliseconds was measured (at 24–30 milliseconds, C_3 was positive in relation to F_3). The increased amplitude of this early SER measurement has been shown previously to indicate a regular and specific change in brain electrical activity that occurs during lithium therapy (9).

Tests of maximum urine concentrating ability were performed using a procedure described by Miller and associates (10). Hourly urine osmolality was measured following 12 to 16 hours of fluid deprivation; dehydration continued until no further increase in urine osmolality occurred. Serum osmolality was then measured and the patient was given five units of aquaeous vasopressin subcutaneously; urine osmolality was measured one hour later.

Lithium carbonate was administered in divided doses at 9 a.m., 3 p.m., and 9 p.m. The patient's behavior between 7 a.m. and 3 p.m. was rated for signs of mania by a research nursing team using a validated 13-item clinical rating scale (11). The sum of scores on three scale items—expression of anger, psychomotor agitation, and hyperactivity-elation—was used to estimate the degree of manic excitement. The patient was maintained on controlled low- and high-sodium diets prepared by the Yale-New Haven Hospital research dieticians.

RESULTS

Renal Concentrating Tests

Renal concentrating tests performed during the patient's hospitalization are summarized in table 1. The first concentrating test was performed when the patient had severe polyuria (8900 ml./24 hrs.). Despite dehydration that was sufficient to elevate the plasma osmolality to 310 mOsm./kg., the urine remained hypotonic to plasma. Urine osmolality reached its highest level at ten hours of dehydration and fell in the next two hours. Exogenous vasopressin restored urine osmolality to a level only slightly greater than that achieved by dehydration (288 mOsm./kg.). Failure to concentrate the urine to levels higher than plasma levels after dehydration and treatment with vasopressin indicates severe nephrogenic diabetes insipidus. The successive fall in urine osmolality with prolonged dehydration (256, 236,

FIGURE 2
Development and Recovery from a Second Manic Episode with Subsequent Reappearance of Polyuria (Days 40 Through 87)

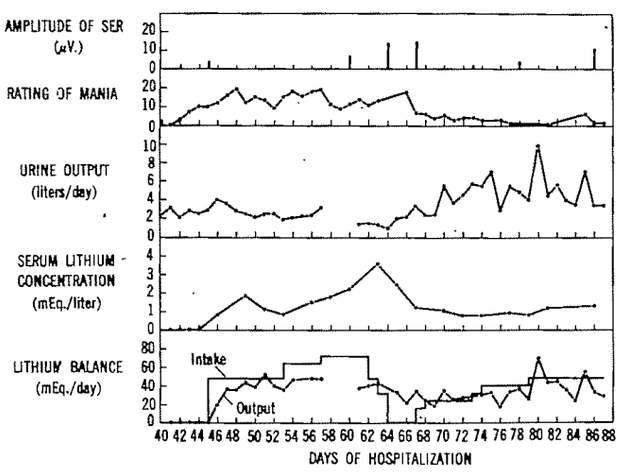


TABLE 1
Serial Renal Concentrating Tests

Day of Hospitalization	Urine Output in Previous 24 Hours (ml.)	Serum Lithium Ion Concentration (mEq./L.)	Urine Osmolality After Dehydration		Plasma Osmolality Before Administration of Vasopressin (mOsm./kg.)	Urine Osmolality One Hour After Administration of Vasopressin* (mOsm./kg.)
			Hours of Dehydration	mOsm./kg.		
16	8900	0.9	10	256	310	288
			11	236		
			12	180		
36	4200	0.0	14	384	295	593
			15	429		
			16	478		
67	3300	1.2	12	198	300	347
			13	230		
			14	246		
86	7100	1.3	12	150	303	150
			13	150		
			14	244		

*Five mg. of aqueous vasopressin.

and 180 mOsm./kg.), followed by modest improvement with exogenous vasopressin (288 mOsm./kg.), may indicate an additional central deficiency of antidiuretic hormone (10).

Eleven days after stopping lithium treatment, the patient continued to have moderate polyuria although no lithium was detectable in serum or urine. Marked improvement in concentrating ability was noted; following dehydration and administration of vasopressin, urine osmolality increased to 593 mOsm./kg. On day 67, by which time lithium had been administered again for 22 days, the patient had manic symptoms and only modest polyuria. A marked impairment of urine-concentrating ability was again observed. When severe polyuria developed (day 86), a further reduction in concentrating ability was noted (urine osmolality = 150 mOsm./kg.). A renal concentrating defect was thus noted both before and during the episode of severe polyuria.

Brain and Electrolyte Studies

The patient's first 40 days of hospitalization are illustrated in figure 1. Urine collections were begun on day 11 in order to investigate the intermittent polyuria that the patient reported during the 18 months she had been taking lithium. From both nursing observations and the patient's self-report, her urine output did not appear to have increased significantly above normal during the period immediately before the onset of urine collections. Polyuria developed during a period of improvement in the patient's manic symptoms. SER measurements indicated a lithium effect on the brain before the onset of polyuria (lithium days 8 and 10 as compared with placebo days 29, 32, 37, and 39). The polyuria appeared and persisted at serum lithium levels in the normal therapeutic range (0.8–1.5 mEq./liter). Raising sodium intake from 100 to 400 mEq./day had no demonstrable effect on the polyuria or on the urinary lithium output. While the patient was receiving a stable lithium dosage (1800 mg./day), her lithium output closely approximated her lithium intake, despite urine volumes as high as 12 liters/24 hrs.

By day 25 (figure 1) the patient's behavior was markedly improved. However, severe polyuria persisted. To evaluate the effect of lithium therapy on this symptom, placebo capsules were substituted for lithium capsules in a double-blind manner. During the next 15 days, urine output slowly fell toward normal levels.

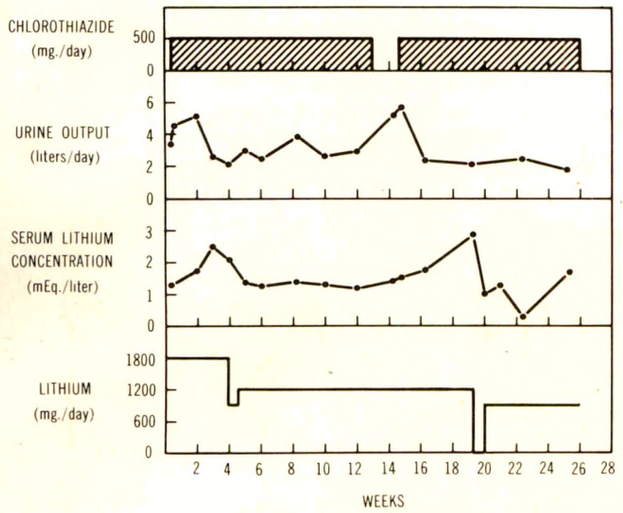
Figure 2 illustrates days 40–87 of the patient's hospitalization. (Sodium balance is omitted from figure 2, since both sodium intake and output remained virtually unchanged from the levels illustrated in figure 1.) The patient became manic after 17 days without lithium. Figure 2 demonstrates the time course of a recurrence of polyuria after a period of normal urine output despite very high serum lithium levels (up to 3.7 mg./liter). As was observed during her first episode, the patient did not develop polyuria during the period in which she was manic. SER amplitudes on days 60 and 64 again indicated a lithium effect on the brain before the development of polyuria. When polyuria did develop, it coincided temporally with an improvement in manic symptoms and persisted at serum lithium levels considerably lower than the peak levels required to control manic excitement.

Intermittent measurements of serum sodium, potassium, chloride, bicarbonate, and creatinine were within the normal range and did not vary in relation to polyuria. Creatinine clearance remained normal despite changes in urine output.

Chlorothiazide Treatment

Since chlorothiazide has been used to reduce urine output in patients with other types of diabetes insipidus (12), an attempt was made to investigate its effect in this case of lithium-induced nephrogenic diabetes insipidus. By day 87 of the study, the patient's behavior had again improved and she had moderate polyuria. At that time she was discharged and began receiving chlorothiazide, 250

FIGURE 3
Decrease in Severity of Polyuria During Two Trials of Chlorothiazide Treatment



mg. at 8 a.m. and 250 mg. at 8 p.m. The patient was seen at regular intervals during this part of the study. Twenty-four-hour urine collections were obtained the day before her appointment. At each appointment, one of the authors (S.T.L.) evaluated the patient for manic symptoms, side effects of lithium therapy, and polyuria. Manic symptoms were not observed at any time during this phase of the study.

The results of chlorothiazide treatment are shown in figure 3. The administration of chlorothiazide resulted in a marked decrease in urine output. When chlorothiazide administration was interrupted for an 11-day period, urine output increased to more than five liters a day on two separate measurements. With reinstitution of chlorothiazide therapy, urine output again fell to normal levels. Each time chlorothiazide therapy was initiated, serum lithium ion concentration rose to more than 2 mEq./liter as urine volume fell. In both instances the lithium dosage was decreased to reduce observed clinical signs of toxicity (e.g., ataxia, slurred speech, lethargy, tremor).

DISCUSSION

In a sample of patients receiving lithium, Forrest and his colleagues demonstrated an increase in thirst and water intake in 40 percent and polyuria (greater than 3000 ml./24 hrs.) in 12 percent (13, 14). The defect in concentrating ability has been shown to be caused by an impaired response to vasopressin by the renal tubules in both man (14, 15) and rats (14, 16). The effect of vasopressin on water permeability is known to be mediated by stimulation of adenyl cyclase in the cell membrane, resulting in an increase in intracellular concentration of cyclic adenosinemonophosphate (AMP). It has been postulated that the inhibitory effect of lithium may result from interference with the stimulation of adenyl cyclase (15, 17) or may occur at a later point in the series of reactions leading to the formation of cyclic AMP (13).

The interaction between sodium and lithium is complex. In this study, a fourfold increase in sodium intake had no demonstrable effect on urine output or on lithium balance (figure 1). This contradicts the finding that increasing the sodium intake decreases the severity of other side effects of lithium (18). In human studies, intravenous administration of sodium chloride has not been found to increase lithium clearance (19).

Improvement in manic symptoms and the onset of polyuria appeared to be temporally related in this patient. If this finding can be corroborated in other patients, it might suggest some common mechanism of lithium action in producing behavioral change and polyuria, possibly through hormonal changes mediated by adenyl cyclase and cyclic AMP in both the brain and the kidney.

Chlorothiazide was found to be effective in controlling this patient's polyuria, thus allowing her to be maintained on lithium. While she received chlorothiazide, the dosage of lithium had to be reduced in order to prevent lithium toxicity.

REFERENCES

1. Gershon S: Lithium in mania. Clin Pharmacol Ther 11:168–187, 1970
2. Schou M: Lithium in psychiatric therapy and prophylaxis. J Psychiatr Res 6:67–95, 1968
3. Baastrup PC, Poulsen JC, Schou M, et al: Prophylactic lithium: double-blind discontinuation in manic-depressive and recurrent-depressive disorders. Lancet 2:326–330, 1970
4. Trautner EM, Morris R, Noach CH, et al: The excretion and retention of ingested lithium and its effect on the ionic balance of man. Med J Aust 2:280–291, 1955
5. Angrist BM, Gershon S, Levitan SJ, et al: Lithium-induced diabetes insipidus-like syndrome. Compr Psychiatry 11:141–146, 1970
6. Lee RV, Jampol LM, Brown WV: Nephrogenic diabetes insipidus and lithium intoxication: complications of lithium carbonate therapy. N Engl J Med 284:93–94, 1971
7. Viol GW, Smith EKM: Vasopressin inhibition by lithium (ltr to ed). N Engl J Med 284:674, 1971
8. Ramsey TA, Mendels J, Stokes JW, et al: Lithium carbonate and kidney function: a failure in renal concentrating ability. JAMA 219:1446–1449, 1972
9. Heninger GR: Lithium effects on cerebral cortical function in manic depressive patients. Electroencephalogr Clin Neurophysiol 27(suppl):670, 1970
10. Miller M, Dalakos T, Moses AM, et al: Recognition of partial defects in antidiuretic hormone secretion. Ann Intern Med 73:721–729, 1970
11. Heninger GR, French NH, Slavinsky AT, et al: A short clinical rating scale for use by nursing personnel, II: reliability, validity, and application. Arch Gen Psychiatry 23:241–248, 1970
12. Crawford JD, Kennedy GC, Hill LA: Clinical results of treatment of diabetes-insipidus with drugs of the chlorothiazide series. N Engl J Med 262:737–743, 1960
13. Forrest JN, Cohen AD, Torretti J, et al: Lithium polyuria: an example of reversible nephrogenic diabetes insipidus (abstract). J Clin Invest 50:32, 1971
14. Forrest JN, Cohen AD, Torretti J, et al: Studies on the mechanism of lithium induced diabetes insipidus in man and the rat (unpublished paper)
15. Singer I, Rotenberg D, Puschett JB: Lithium-induced nephrogenic

diabetes insipidus: in vivo and in vitro studies. J Clin Invest 51:1081–1091, 1972
16. Harris CA, Jenner FA: The inhibition of the action of vasopressin by lithium ions (abstract). J Physiol (London) 200:59, 1969
17. Dousa T, Hechter O: The effect of NaCl and LiCl on vasopressin-sensitive adenyl cyclase. Life Sci [I] 9:765–770, 1970
18. Demers RG, Heninger GR: Sodium intake and lithium treatment in mania. Am J Psychiatry 128:100–104, 1971
19. Thomson T, Schou M: Renal lithium excretion in man. Am J Physiol 215:823–827, 1968

Lithium-Induced Folliculitis

BY ARTHUR RIFKIN, M.D., STEPHEN B. KURTIN, M.D., FREDERIC QUITKIN, M.D., AND DONALD F. KLEIN, M.D.

Twelve patients receiving long-term treatment with lithium developed folliculitis on their extremities and/or trunks. The rash disappeared in three patients who discontinued lithium therapy, and in one patient it reappeared when she again received lithium. The authors concluded that folliculitis is a common, but not serious, side effect of lithium treatment.

IN THIS REPORT we describe 12 patients, aged 16 to 53, who were treated with lithium carbonate and who developed folliculitis, a hitherto unreported side effect. Ten of the 12 patients were women.

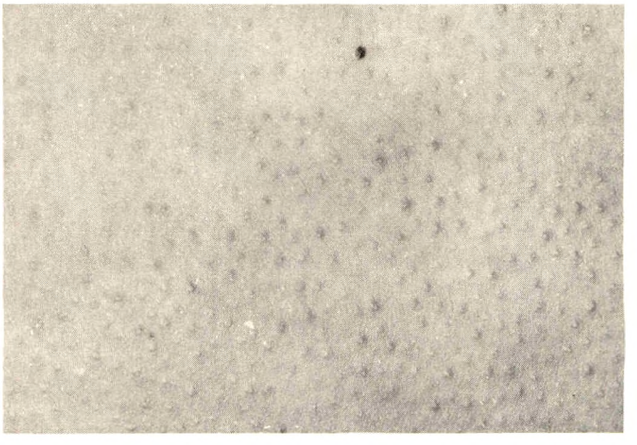
Callaway and associates (1) described five patients with cutaneous reactions to lithium. Four had pruritic maculopapular eruptions (two also had cutaneous ulcers of the lower extremity) and one had a leg ulcer without an associated rash. These symptoms responded to a reduction in lithium dosage or to treatment with a steroid cream.

Kusumi (2) reported on two patients with a skin rash that was attributed to lithium treatment. The rash was described as small pruritic acneform papules that appeared on the face, neck, breast, groin, and axilla; they developed to pustules and finally coalesced to form erosions before subsiding. One patient's rash cleared up despite the continued use of lithium while the other patient's lesions rapidly subsided after lithium treatment was discontinued. Readministration of lithium did not produce recurrence of the skin reaction. In both patients the rash began within a week of the start of lithium treatment.

In general, these reactions are very similar to those described by Callaway and his colleagues (1), but quite different from the cutaneous reactions we observed. Posey (3) also described a patient who was receiving lithium and developed a papular, intensely pruritic dermatitis on the elbows that resembled early dermatitis herpetiformis. The itching responded promptly to treatment with sulfoxone sodium. This lesion also differs from the folliculitis we observed because of its herpetiform morphology and the intense pruritis. There have been no other reports of cutaneous reactions to lithium.

We have observed folliculitis in 12 patients, or about a third of our patients receiving lithium for at least six months. The eruption consisted of hyperkeratotic, erythematous, follicular papules, located predominantly on the extensor surfaces of the arms and legs, but in some patients extending to the buttocks and sides of the abdomen. The eruption was asymptomatic. Microscopic examination revealed a dilated hair follicle filled with kera-

FIGURE 1
Extensor Surface of the Right Thigh Showing Hyperkeratotic, Erythematous, Follicular Papules

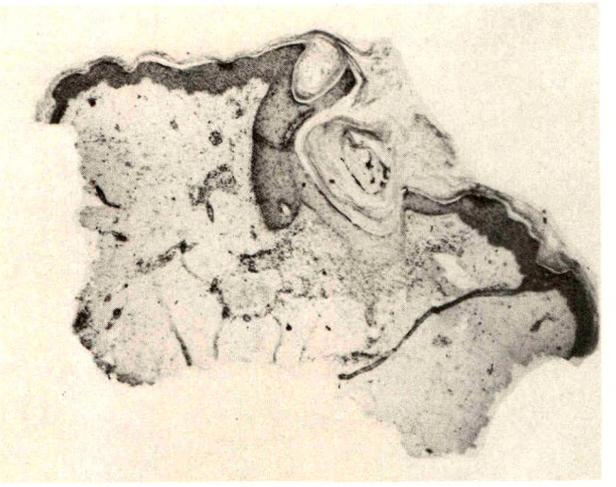


Dr. Rifkin is Director of the Aftercare Clinic, Dr. Quitkin is Staff Psychiatrist, and Dr. Klein is Medical Director (Evaluation), Hillside Division, Long Island Jewish-Hillside Medical Center, P.O. Box 38, Glen Oaks, N.Y. 11004. Dr. Kurtin is Clinical Associate, Department of Dermatology, Mount Sinai School of Medicine, New York, N.Y.

tin and parakeratotic material. The upper dermis contained a mixture of inflammatory cells localized around small blood vessels and hair follicles (see figures 1 and 2).

The eruption appeared after the patient had been taking lithium for a period of one to 12 months. Six patients were taking other medications at the time the rash appeared. In three patients the rash cleared up when the lithium was discontinued. In one of these three, the rash subsided when lithium was discontinued, but reappeared when the patient again took the drug; the rash cleared up again when she discontinued the drug. When she received lithium for the third time the rash did not reappear. Six patients had complete or partial clearing up of the eruption while continuing to take the lithium. Two patients were treated with a steroid cream while continuing to take lithium; one showed a partial improvement and the other showed no response.

FIGURE 2
*Photomicrograph Showing a Dilated Hair Follicle**



*The follicle is filled with keratin and parakeratotic material and the dermis shows a moderate number of lymphocytes, histiocytes, and polymorphonuclear leukocytes localized mainly about small blood vessels and the hair follicle.

DISCUSSION

Clinically, the folliculitis produced by lithium resembles keratosis pilaris. Both occur on the extensor surfaces of the limbs and both involve hyperkeratosis of the follicular opening. However, the folliculitis produced by lithium has a marked inflammatory component that is easily observed. None of the patients gave a history of having keratosis pilaris before receiving lithium. There was no seasonal variation, as seen in keratosis pilaris, and the disease was dependent on the patient's receiving lithium, since it cleared when the lithium therapy was discontinued.

A leading textbook of dermatology (4) does not mention any drug as producing folliculitis. Baer and Harris (5), in their review of types of cutaneous reactions to drugs, do not list folliculitis. Halogens, such as iodine, bromine, chlorine, and fluorine, can produce a follicular eruption but it is not limited to the extremities and is usually acneform (6). Hyper- and hypovitaminosis A can produce hyperkeratotic folliculitis, but the folliculitis is not limited to the extremities, as it was in our patients receiving lithium, and there are other signs and symptoms that were not seen in our patients.

The gradual onset of the eruption, the fact that it often improves spontaneously while drug therapy is continued, and the fact that it is seen quite commonly in patients receiving lithium all imply that this is a physiological, rather than an allergic, reaction to lithium. This type of folliculitis, with its distribution over various parts of the body, is a unique cutaneous reaction, caused only by lithium. Except for a minor cosmetic problem, the folliculitis caused by lithium seems not to be harmful to the patient, and we do not feel that it is sufficient reason for discontinuing drug therapy.

REFERENCES

1. Callaway CL, Hendrie HC, Luby ED: Cutaneous conditions observed in patients during treatment with lithium. Am J Psychiatry 124:1124–1125, 1968
2. Kusumi Y: A cutaneous side effect of lithium: report of two cases. Dis Nerv Syst 32:853–854, 1971
3. Posey RE: Lithium carbonate dermatitis (ltd to ed). JAMA 221: 1517, 1972
4. Rook A, Wilkinson DS, Ebling FJG: Textbook of Dermatology. London, Blackwell, 1968
5. Baer RL, Harris H: Types of cutaneous reactions to drugs. JAMA 202:710–713, 1967
6. Hitch JM: Acneform eruptions induced by drugs and chemicals. JAMA 200:879–880, 1967

EDITORIAL

Fewer Special Sections in the Offing

SINCE SHORTLY AFTER THE PRESENT EDITOR took over the pleasant if somewhat demanding task of editing the official journal of the American Psychiatric Association, we have made an effort to get together in nearly every issue a special section on a topic we believed to be of interest to the membership. In planning the special sections we utilized the papers on the subject we had on hand. Often we were aided in our efforts by an opportunity to choose from among the papers presented at a session on that topic at the annual meeting. But unfortunately these annual meeting papers were not always of equally high caliber; some had even been recommended for rejection by our reviewers. Also, we were admittedly sometimes guilty of procrustean methods and reached out for a paper that did not quite fit in order to fill out a special section—an action comparable to trying to fill out an inside straight.

Mind you, some of the special sections were excellent, and we have been complimented by teachers and prospective authors alike for gathering together papers on a subject in a way that could be useful to them in their teaching or literary efforts. But all the while we were aware of two drawbacks to this attempt to be of service. One was the necessity of delaying publication of papers that seemed to fit in a special section planned for the future; in the normal course of events such papers might have been published several months earlier. Conversely, other papers were pushed ahead because they seemed to fit in well with a special section nearly ready for publication. Second—and much more important—was our realization that having a special section in our official journal might suggest to some readers that we were presenting the last word on the topic. Unfortunately, that was not always true.

Although we recognized these problems, we hesitated to change a practice that had been shown to have some usefulness. Recently, however, our own misgivings have been deepened by some comments we have had from others. Consequently, we have decided to decrease the number of special sections, reserving this format for groups of papers that we are reasonably confident represent an up-to-date and well-rounded exposition of a topic.

At the same time we will take two steps to help fill the void left by cutting down on special sections. First, we will continue (and even accelerate) our policy of requesting individuals who are expert in a special aspect of our discipline to prepare an overview article on that aspect. Second, starting with this issue we will group papers related to a given subject within the *Journal* (although not in every issue), but we will not mention this on the cover of the *Journal*. We are also adding an Editor's note to this section explaining that we do not consider this group of papers to constitute a comprehensive analysis of the topic.

In this section, the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

Along with these modifications we again call attention to the fact that we stand ready to publish in the first available issue any new scientific material submitted by authors desirous of establishing priority of a finding or idea. These reports should not ordinarily exceed eight double-spaced typed pages in length (and could be much shorter) and will of course have to undergo the careful scrutiny to which all our scientific and scholarly papers are subject. An author desiring consideration of his or her paper under this "fast publication" policy should state so in his or her letter transmitting the manuscript.

The Editor invites comments on the ideas set forth in this editorial. The *Journal* will best meet its readers' needs when the readers let us know how they feel about what we are doing.

F.J.B.

BRIEF COMMUNICATIONS

The Treatment of Depression with a Single Daily Dose of Imipramine Pamoate

BY J. MENDELS, M.D., AND JOSEPH DIGIACOMO, M.D.

A controlled comparison of the effects of 50 mg. of imipramine hydrochloride given three times daily and 150 mg. of imipramine pamoate in a single bedtime dose revealed no significant difference in either therapeutic effects or side effects in a group of 40 hospitalized depressed patients. The authors note the advantages of a single night dose of antidepressant medication.

THE TRICYCLIC ANTIDEPRESSANTS have become one of the main methods for the treatment of depressed patients. These drugs are usually prescribed in divided doses throughout the day. However, since their antidepressant effect is usually not apparent for about two weeks after the initiation of treatment and is therefore probably not related to this divided dose pattern of administration, it is possible that this practice is more the result of conventional medical procedure than rational therapeutics. Furthermore, these drugs have side effects that can cause discomfort and interfere with the patient's ability to function effectively. This is especially true when the main symptoms of depression have cleared and the drug treatment is being maintained. For example, patients receiving imipramine may complain of a sedative effect that may interfere with work or driving an automobile.

There are also reports that many psychiatric outpatients do not take their medication as prescribed (1). It is not unreasonable to assume that prescribing a single dose to be taken in the evening may result in the patient's taking his medication more regularly than if he were on a several-times-a-day schedule.

Dr. Mendels is Professor and Chief, Depression Research Unit, and Dr. DiGiacomo is Associate Professor, Department of Psychiatry, University of Pennsylvania, Philadelphia, Pa. They are also with the Philadelphia Veterans Administration Hospital, University and Woodland Aves., Philadelphia, Pa. 19104; reprint requests should be sent to the latter address.

This work was supported in part by research funds from the Veterans Administration. Study capsules and support were provided by Geigy Pharmaceuticals.

METHOD

Subjects included patients admitted to a psychiatric inpatient service in a general hospital who were suffering from a psychiatric illness with a primary diagnosis of depression and for whom the clinician prescribed an antidepressant drug.

These patients were characterized by complaints of feeling sad, blue, and depressed; feelings of inadequacy, guilt, and remorse; suicidal ideas and attempts; loss of appetite and weight; and sleep disturbance. Patients who had symptoms suggestive of schizophrenic illness, organic brain syndrome, alcoholism, or drug abuse were excluded. Forty consecutive patients who met the criteria for inclusion and who had a minimum score of 15 on the Hamilton Depression Rating Scale (2) were included in the study.

All patients received three identical capsules daily. They were assigned according to a random number table to one of two groups. The first group received 50 mg. of imipramine hydrochloride three times a day. The second group received placebo capsules during the morning and afternoon and 150 mg. of imipramine pamoate in a single dose in the evening. Neither patients nor psychiatrists knew which set of capsules was administered to any patient.

Clinical change was measured by a self-rating depression inventory that consisted of 21 items (3) and by global evaluations of the severity of depression and anxiety. Separate ratings based on the patient's verbal reports, interview behavior, and secondary symptoms of depression or anxiety were made. Each was rated on a 1–6 scale in which 1 represented the absence of anxiety, 2 the presence of minimal, 3 of mild, 4 of moderate, 5 of severe, and 6 of extreme anxiety. Ratings were made before treatment started and repeated weekly. All patients were treated for at least 21 days unless there was sufficient clinical improvement to justify discharge from the hospital before the end of this period. No patient was treated for less than 14 days.

Blood pressure, pulse, respiration, and temperature were recorded on acceptance to the study to establish

TABLE 1
Effect of Treatment on Mood Rating Scales

Rating Scale	Imipramine Hydrochloride			Imipramine Pamoate*		
	Pretreatment (Mean)	Posttreatment (Mean)	Significance	Pretreatment (Mean)	Posttreatment (Mean)	Significance
Depression Inventory (DI)	23.8	9.5	$p<.01$	22.2	11.4	$p<.01$
Global Depression Rating (GDR)	12.1	6.1	$p<.01$	11.6	5.6	$p<.01$
Global Anxiety Rating (GAR)	6.4	4.3	$p<.01$	5.9	3.9	$p<.01$

*Comparison of the extent of changes on all three rating scales for the two drug groups revealed no significant difference in the degree of improvement (DI, $t=0.88$; GDR, $t=0.74$; GAR, $t=0.88$). None of the pretreatment scores of the two groups showed any significant difference.

baseline and at points throughout the study. Laboratory investigations—including a complete blood count, platelet count, serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and alkaline phosphatase—were done before the initiation of the study, at least once during the study, and on completion of the study. Side effects and adverse reactions were recorded as they occurred.

RESULTS

Forty patients were studied. Nineteen received imipramine pamoate (14 men and 5 women: mean age 46 years), and 21 received imipramine hydrochloride (13 men and 8 women: mean age 44 years).

Table 1 shows the pre- and posttreatment ratings on the three scales for the two groups of patients. There was a statistically significant improvement in both groups according to all three scales ($p < .001$; two-tailed t test). The degree of improvement was not significantly different for the two treatment groups according to any of the change measures employed. Other measures designed to determine whether there was any significant difference in the clinical response to the two treatment methods, such as the number of days of treatment before discharge from the hospital or global evaluation of clinical improvement, also revealed no significant differences between the two groups.

Relatively few significant side effects were noted. There were few significant alterations in laboratory measures, blood pressure, pulse, or respiration. The changes that were noted were in all instances transient. In particular, no patients who received 150 mg. of imipramine in a single nighttime dose developed orthostatic hypotension, while one patient in the other group developed this symptom. Other notable side effects are noted in table 2. (Included here are all recorded events that were classified as definite, probable, or possible.)

TABLE 2
Side Effects of Imipramine Pamoate and Imipramine Hydrochloride

Reaction	Number of Reactions*	
	Imipramine Pamoate	Imipramine Hydrochloride
Blurred vision	2	0
Dry mouth	1	0
Hard stools, straining	1	0
Lightheadedness	2	0
Orthostatic hypotension	0	1
Rash (erythematous, pruritic, macular papular)	0	1
Things lighter and brighter	1	0
Thirst	1	0
Tremor	1	0
Unsteadiness of gait	1	0
Total patients with reactions**	4	2
Total withdrawn from study because of reactions	2	1

*Only those reactions classified as definite, probable, or possible.
**Several patients developed more than one side effect.

DISCUSSION

This prospective study comparing the clinical effectiveness and safety of imipramine hydrochloride in divided doses and imipramine pamoate in a single nighttime dose strongly suggests that there are no significant differences between the two drugs in terms of either their antidepressant effects or their safety.

Saraf and Klein (4) reported a retrospective survey of 43 patients treated with single nightly doses of imipramine hydrochloride (mean dose of 135 mg.). They concluded that there was no loss in therapeutic efficacy and that undesirable side effects were less commonly observed than in the patients given imipramine several times a day. Both patients and nurses found the single dose schedule to be more convenient. We have also had considerable experience (but not in a controlled study) with giving 150–200 mg. of imipramine hydrochloride in a single dose at nighttime; we have formed the strong impression that it is more acceptable to most patients. In

many instances the patients had been started on the usual drug schedule but complained of side effects, which were either causing discomfort or were interfering with their ability to function during the day. Changing to a single nighttime dose eliminated many of these effects. However, this observation requires further validation.

These observations suggest that a single nightly dose of imipramine may be associated with increased convenience and patient acceptance and may increase the reliability with which outpatients take their medication (as compared with a three-times-a-day schedule). It is also our impression (to be confirmed in controlled studies) that patients given a single large dose of imipramine at nighttime complain less of insomnia, reducing the need for an additional sedative.

It should be remembered that imipramine has a stimulatory effect on a few patients, who may not be able to tolerate a single dose at nighttime. Attention must also be paid to the possibility of the patient's developing orthostatic hypotension, but the available evidence suggests that this is not likely to occur more frequently in patients given a single dose than in those receiving divided doses.

REFERENCES

1. Blashki TG, Mowbray R, Davis B: Controlled trial of amitriptyline in general practice. Br Med J 1:133–138, 1971
2. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 23:56–62, 1960
3. Beck AT, Ward CH, Mendelson M, et al: An inventory for measuring depression. Arch Gen Psychiatry 4:561–571, 1961
4. Saraf K, Klein DF: The safety of a single daily dose schedule for imipramine. Am J Psychiatry 128:115–116, 1971

Time-Extended Group Therapy Sessions in a Remote Setting

BY JOHN RECKLESS, M.B., CH.B., DAVID HAWKINS, M.D., AND ALEXANDRA FAUNTLEROY

This preliminary report draws attention to an innovative group therapy technique that may be beneficial to couples with sexual and emotional difficulties and that may lend itself to more intensive, effective treatment of shorter duration than traditional modes of marital therapy. The authors caution, however, that it should be attempted only by well-trained therapists with a stable working relationship and only with a cohesive, mutually supportive group.

WORK WITH MARRIED COUPLES in therapy groups has proven effective and is well documented in the literature. In addition, the use of "marathons" or time-extended group meetings, particularly those involving the use of encounter and nonverbal techniques, is accepted as a means of opening new areas for investigation, getting through particularly tenacious resistances, and, in general, expediting the process of dynamically oriented psychotherapy. In this paper we will report on the innovative use of time-extended sessions in a remote setting as an adjunct to an ongoing couples therapy group meeting regularly once a week.

The group was composed of four married couples, one engaged couple, one man whose wife was no longer in the group, and three cotherapists (the authors). The members had originally been referred to one of us (J.R.) because of sexual and emotional difficulties in their marriages. At the time of the first extended meeting all of the group members had worked together for at least five months, and half had worked in essentially the same group for at least two years. We had worked as a team for three years in this and other similar groups. The value of using therapists of both sexes in the treatment of patients with psychiatric and psychosomatic illnesses has previously been described by Reckless and Fauntleroy (1). In addition, Reckless had described the value of direct confrontation techniques with married couples (2). The group usually met for two hours each week, and we often incorporated Gestalt, encounter, and other nonverbal techniques into our basically psychodynamic approach.

Approximately three times each year the group had held extended sessions over a weekend, meeting for six hours on Saturday and five hours on Sunday. These extended sessions were particularly useful and were used as reference points by the members in discussing their insights and change. More especially, we felt that a peak of cohesion and involvement was reached that was therapeutically effective beyond mere facilitation. This idea,

Dr. Reckless is in private practice at the John Reckless Clinic, 5504 Durham-Chapel Hill Blvd., Durham, N.C. 27707, where Ms. Fauntleroy is Clinical Consultant. He is also Lecturer in Nursing, Duke University School of Nursing. Dr. Hawkins is Coordinator of Adult Psychotherapy Supervision, Duke University Medical Center, Durham, N.C.

highlighted by members' statements that even though they met in the usual therapy room they felt an unusual closeness and freedom from distraction, led to our proposal that the group hold its extended sessions at a nearby mountain resort.

In this paper we describe three such meetings held at intervals over a one-year period. In the final format that evolved, the members drove to the resort on Friday afternoon and extended sessions were held for approximately five hours on Friday evening, five hours Saturday evening, and three hours Sunday morning. All the members stayed together in a large rented chalet and shared chores such as the preparation of meals. We stayed at a nearby home and were available by phone at all times. During the nonscheduled times the members availed themselves of outdoor sports, took walks, and generally structured their activities as they wished. Listening to music and social dancing occurred spontaneously after most of the evening meetings. All sessions were recorded on audio tapes and were available for later review by the members (a technique described by Reckless [3]).

REACTIONS TO THE SESSIONS

In addition to the reactions voiced by the members during the therapy sessions and in the weekly group meetings, response to the experiences was assessed by means of questionnaires that inquired about fantasies and fears and events of special significance, and included detailed rank-order questions as to who was helped or harmed by the experience, by whom, and how. A more detailed analysis of the experience is in process and will require the collection of more data, but the members' spontaneous statements indicated that two aspects were of paramount importance to them. They felt geographically removed from pressures, obligations, and the routine of family and job; and they seemed profoundly moved by the experience of intimately sharing not only the actual therapeutic material, but chores, quiet times, difficulties (a blizzard), and the beauty of the mountain setting.

From our viewpoint there were several aspects of the experience that warrant particular comment. First, we had already worked intensively with all of the members of this group and felt that they had a good understanding of one another's problems, defenses, and strengths. This is of special note since a common criticism of extended-time group experiences is that they are often done with little or no screening and follow-up of the participants. But despite our prior feel for the members, we were amazed at the new insights we gained on seeing them in a new setting. Second, we had already done considerable work with each other in developing a stable working relationship. However, this new experience, with its pressures, brought forth strong affective responses that required more and not always easy work on our relationship and that opened new areas to us, resulting in our being able to work much more comfortably, effectively, and creatively in the group.

Also, we were most impressed with a quality that might best be called intensity of involvement. Many members mentioned that in the week or so preceding the meeting they experienced symptoms of increased anxiety and mobilization of both positive and negative feelings toward the other members and us. Several were able to describe resolving to explore and work on areas that, during this anticipatory period, they realized they had avoided handling in the regular sessions. By the same token, we found ourselves confronting areas of the patients' behavior that they had been somewhat aware of but had chosen to ignore. One result of this was that one young couple were able to face a strong resistance, by which they had appeared quite busy but were actually avoiding tackling their real concerns, and they decided to postpone a move to another city so that they could continue therapy.

REACTIONS REQUIRING SPECIAL ATTENTION

Some intensification was more difficult to handle. One fairly withdrawn member had been in the group for four years, and although his progress had been remarkable considering his original presenting problems, and he was well liked by the other members, he remained very much a passive participant. He was receptive to and very affected by the warmth and involvement other members displayed toward him but was unable to request this for himself. For at least two years he had been able to recognize both his fear and positive anticipation of extended meetings, but this escalated sharply during the three extended sessions described here. By the third session his anger at not being able to obtain more directly the warmth and involvement he so desperately wanted and had gradually allowed himself to passively receive reached such an intensity that suicide was a serious threat. We feel that it was the same intensity of involvement, however, that carried him through this precarious period. It was not so much our interpretations but the intense, almost palpable concern of the other members that communicated hope to him.

In a few other instances it was not the member's resolve to understand a problem area that became intensified in anticipation of the mountain meeting, but rather a strong transference wish, which resulted in the member's coming to the session consciously or unconsciously resolved to have a "showdown." This deserves special note because it seemed to us to be a situation in which harmful acting out (aggressive, sexual, etc.) could most likely occur. Three factors permitted the successful resolution of these situations.

1. The strongly supportive atmosphere enabled the member to get more in touch with his wish and continue (as often happened) to receive comfort and healthy support, even during his most irrational outbursts, as he expressed the wish and then examined his own behavior.

2. We held a meeting prior to each session in which we outlined potential highly charged areas for each participant and an extended meeting immediately after each

session in which we compared our perceptions and reviewed the work.

3. Our pattern of working together permitted the one or two therapists least involved in the transference to become most active in helping the member elucidate his feelings toward the other therapists or therapist.

Finally, it seemed that toward the end of the weekend experience, after some of the more intense feelings had been expressed and some new insights reached, a mood of honest receptivity prevailed among the members and that more openness on our part appeared warranted and helpful.

RECOMMENDATIONS

We would like to reiterate certain points as a precaution. As with many therapeutic tools, the use of the time-extended session in a remote setting is potentially harmful. The intensification of feelings and involvement fostered by the removal of the routine of home and job and close affective proximity for 42 hours makes usual defenses and coping mechanisms less stable and adequate for members and therapists alike. We strongly advise that this be attempted only by well-trained therapists who have achieved a stable working relationship with each other and only with a carefully screened group that has already achieved enough cohesion to offer mutual support and in which each member has been observed functioning under similar but less intense group stresses.

REFERENCES

1. Reckless J, Fauntleroy A: Groups, spouses and hospitalization as a trial of treatment in psychosomatic illness. Psychosomatics 13:353–357, 1972
2. Reckless J: A confrontation technique used with married couples in a group therapy setting. Int J Group Psychother 19:203–213, 1969
3. Reckless JB: Audio-visual feedback in group psychotherapy: a method using tape recordings and 'still-colour' photographs. Can Psychiatr Assoc J 17:331–332, 1972

The Nonpsychotic Organic Brain Syndrome

BY BENJAMIN FELDSHUH, M.D., JANET SILLEN, BARBARA PARKER, M.D., AND WILLIAM FROSCH, M.D.

The New York State mental hospital system has recently limited the admission of the "simply senile," those with organic brain syndrome who are neither psychotic nor severely depressed. The authors studied 53 such people and concluded that these patients are usually severely ill and often need psychiatric hospitalization before their placement in the community.

THE GERIATRICS EVALUATION AND SERVICE UNIT has recently studied 116 people over age 65 who were admitted to the Bellevue Hospital Psychiatric Division. Fifty-three of these patients were diagnosed as having an organic brain syndrome without a primary diagnosis of psychosis or depression. These cases are often labeled as "simply senile" because of the absence of psychosis or severe depression. The exclusion of the "simply senile" from the New York State mental hospital system has deprived such individuals of psychiatric hospital care (1). Our examination, however, suggests that although they are nonpsychotic, they are severely ill and confused, and they often need psychiatric hospitalization before placement in the community.

Dr. Feldshuh is Director, Dr. Parker is Internist, and Ms. Sillen is Coordinator of the Geriatrics Evaluation and Service Unit, Bellevue/New York University Medical Center, First Ave. at 30th St., New York, N.Y. 10016. Dr. Frosch is Professor, Department of Psychiatry, New York University, New York, N.Y.

This work was supported in part by a grant from the New York State Department of Mental Hygiene.

The authors wish to thank Mr. Sam Diebler, who at the time of this work was Protestant Chaplain of Bellevue Hospital, for the coding work and Drs. Hardesty and Burdock of the New York University Medical Center Biometrics Department for their statistical work.

THE PROGRAM

The Geriatrics Unit was created to find alternatives to state hospitalization (2). This followed the decision by the New York State Mental Hygiene Department to limit the admission of geriatric cases to the state hospital system. Patients who could no longer be admitted to a state hospital became the direct responsibility of the local community and were the source of our study population. When an elderly patient came to the Bellevue Psychiatric Emergency and Admitting Service for treatment, he was

TABLE 1
Severity of Illness by Diagnostic Category (N = 116)

Severity of Illness	N	Diagnostic Category				
		Organic Brain Syndrome		Adjustment Reaction	Depression	Other Diagnosis*
		Nonpsychotic	Psychotic			
Normal	11	4	0	4	0	3
Borderline	9	1	2	2	4	0
Mildly ill	15	9	2	1	1	2
Moderately ill	38	23	4	3	8	0
Severely ill	23	9	5	1	7	1
Data not available	20	7	0	1	3	9
Total	116	53	13	12	23	15

*Nine subjects had no diagnosis or had not been diagnosed before being removed from the study. See text for discussion.

referred to the geriatric project. All patients received complete physical and psychiatric examinations, a social service evaluation, laboratory tests (including electrocardiogram, chest X ray, routine urine analysis, and blood work), and other special examinations when needed. The patient's psychiatric status was evaluated by a mental status examination and a problem appraisal analysis.[1] Diagnosis was assigned in accordance with APA's *Diagnostic and Statistical Manual of Mental Disorders*, second edition (*DSM-II*) (3). A community worker was assigned to each case to maintain contact with the patient. This contact was continued during all phases of evaluation and treatment, both inpatient and outpatient.

DIAGNOSIS

The diagnoses of the first 116 patients evaluated are shown in table 1. Fifty-three were diagnosed as having organic brain syndrome without psychosis. The criteria for diagnosis were those listed in *DSM-II*: impairment of orientation or memory; deterioration of intellectual functions such as comprehension, calculation, or knowledge; impairment of judgment; and lability and shallowness of affect. An additional 13 patients were diagnosed as having organic brain syndrome with psychosis. These 13 patients, in addition to the organic brain syndrome, showed evidence of poor contact with reality, presence of delusions and hallucinations, and a degree of functional impairment severe enough to disturb the patient's contact with reality. Mood alterations, deficits in perception, and language and memory impairment were severely altered in this latter group. We were unable to describe the etiology of the organic mental syndrome in these 66 patients showing organic brain syndrome with or without psychosis except in those cases where a history of a stroke was present or focal neurological signs were found. An additional 12 patients were diagnosed as experiencing adjustment reactions of late life. These frequently included normal responses to realistically disturbing situations such as illness, loss, or isolation. Twenty-three other patients showed either neurotic or psychotic depressions. Usually these represented the recurrence of previous depressive illness, in some cases in response to the stress of aging. Two patients were diagnosed as schizophrenic and 13 patients had a variety of disorders including alcoholism, mania, sociopathy, and a few acute brain syndromes that resulted from physical illness. An additional nine subjects had not received a diagnosis before their families removed them from the hospital.

Severity of Illness

The problem appraisal analysis is based upon the mental status examination. It includes three separate scales: a global or overall rating of severity of illness, an incapacitance scale that is a measure of functional impairment, and an item or symptom scale. A global scale may be more sensitive to subtle changes in conditions that are not referrable to a specific symptom. The symptom scale gives a profile of pathology that is often useful. The incapacitance scale is helpful because descriptive severity of illness and function in society are not necessarily identical. An incapacitance scale reflects the latter ability.

Table 1 presents the global severity of illness by diagnostic group. One can see that the patient with a nonpsychotic organic brain syndrome is as likely to be rated moderately or severely ill as patients with a psychotic organic brain syndrome or other diagnosis. Parallel findings may be seen in table 2, where the incapacitance ratings are also presented by diagnosis. Thirty-six of the 48 patients with nonpsychotic organic brain syndrome for whom this information was available required either a sheltered community or hospitalization. Thus 75 percent of these patients were unable, even with help, to care for themselves in the community. This may reflect the greater number of symptoms found at the time of admission in patients with the nonpsychotic organic brain syndrome than in patients with a diagnosis of psychotic organic brain syndrome. The nonpsychotic patient had

[1] The Problem Appraisal Form of the New York State Department of Mental Hygiene has been modified for use at Bellevue Psychiatric Hospital. This modification was used for the study.

TABLE 2
Adjustment Capacity by Diagnostic Category (N=116)

Current Psychiatric Condition	N	Diagnostic Category				
		Organic Brain Syndrome		Adjustment Reaction	Depression	Other Diagnosis
		Nonpsychotic	Psychotic			
Satisfactory community adjustment possible	10	1	0	4	1	4
Care of self in community with help possible	23	11	3	4	4	1
Needs sheltered environment in community	29	22	2	1	4	0
Needs hospitalization	37	14	8	2	12	1
Data not obtainable	17	5	0	1	2	9
Total	116	53	13	12	23	15

between ten and 13 symptoms, the psychotic patient only seven to nine. Curiously, although both groups were diagnosed as having organic brain syndrome, the nonpsychotic patients showed more disturbance of orientation, memory, associations, and affect, as well as impairment of judgment and insight. In addition, they had more physical difficulties and disturbances with others, including family members. A significant number had a depressed mood that further complicated the clinical picture. It may be that the community is more tolerant of confused than of psychotic behavior. The psychotic with a mild organic brain syndrome may behave in a way that rapidly brings him to the attention of others. This would result in hospitalization relatively early in the course of the illness, before the development of additional symptoms.

Clinical Picture

The following case reports are presented as typical of the patients we examined.

Case 1. Mrs. A. was brought to the hospital by the police. She had been found on the streets dressed in an old housecoat, dirty and without identification or money. On examination, it was clear from her physical condition that she had been without proper housing or nutrition for some time. She insisted that she was 45 although she looked aged. She could not understand why she had been brought in from the street. In the hospital she remained dirty and unable to care for herself. After considerable difficulty a son was located in the midwest. Information obtained from her son indicated that she was 70 years old; she had been a nurse and her deceased husband had been a physician. Her son said that she had been wandering from place to place in recent years and was glad that she had again been found. Although she was not grossly psychotic, her inability to care for herself, coupled with her wandering behavior, required that she be placed in a long-term compulsory-care institution.

Case 2. Mrs. B. was found picking garbage out of a trash can in front of a school. The schoolchildren told their teacher, who notified the police. When they brought her to the hospital she did not remember who she was and had no identification. She finally mentioned a small town and we were able to obtain her history from a neighbor. The patient had a small home in upstate New York and came to New York City regularly to withdraw money from a bank. On this occasion she apparently became acutely confused in the bus terminal and then wandered through the city. On initial examination, she was unable to remember the details of her life or carry on a coherent conversation. In addition, she appeared somewhat depressed. We were able to arrange for her return to her familiar environment and neighbors and for continuing supervision by a local social service agency.

Case 3. Mr. D. had a physical illness that limited his ability to manage his affairs, restricted his locomotion, and produced a dependency that one would not expect in a man of his years. He became somewhat depressed, lost his appetite, and slept poorly; there followed the rapid development of marked memory impairment. He was diagnosed as having nonpsychotic organic brain syndrome. Although the hospitalization at Bellevue relieved his depressive symptoms, the patient's gross memory difficulties and inability to care for himself required long-term care.

The onset of the nonpsychotic organic brain syndrome in these patients was typically rather abrupt. It was often precipitated by physical illness, such as pneumonia, stroke, or fracture, or by environmental stress, such as a robbery, mugging, or losing an apartment because of urban redevelopment. Within a week to a month after the onset of the illness, the patient was in need of external support. Amnesia, confusion, and inappropriateness of response led to social deterioration and hospital referral.

The degree of illness at the time of admission to the unit was not necessarily predictive of outcome. Particularly for those patients in whom the syndrome was precipitated by physical illness, treatment of the primary physical illness, even when unrelated to the organic brain syndrome, often resulted in its amelioration. In addition, in the nonpsychotic group many patients were able to adjust to the deficit and, with some support from the community, to return to their homes. Drugs for sleep, tranquilizers for agitated behavior, food, and attention by the unit staff helped organize the life of the elderly patient in the hospital. In our experience, the earlier this hospital referral was made, the better the prognosis. The patient with an organic brain syndrome left within the community without help is exposed to further mental deterioration and superimposed physical illness. In the central cities he becomes a target for attack. Hospitalization and treatment often prevented the deterioration that results

from impaired self-care and inability to cope with the world.

These findings confirm previous reports (4–6). The importance of early case finding is emphasized in the San Francisco experience (5) and the experience of other similar geriatric services. Drs. Simon and Cahan (4) described the patient with acute organic brain syndrome as needing medical care to alleviate the disorganization resulting from medical illness. Some patients who are treated belatedly have lost resources—physical and economic—that would otherwise have enabled them to continue in the community. They then find their way to the state hospital (6).

CONCLUSIONS

Nearly one-half of the patients seen by the Geriatrics Unit were diagnosed as being "simply senile," i.e., as having nonpsychotic organic brain syndrome. In the past most of these patients would have been sent to state hospitals for further care. Our evaluation—psychiatric, medical, and social—suggests that these patients did indeed require a period of hospitalization for diagnosis and appropriate planning. If sufficient community supports (e.g., housing, housekeepers, visiting nurses) were available, many of these patients could be returned to the community. However, it is important to keep in mind that much of the central city is not a community in this supportive sense. Needed services are often not available. We were unable to mobilize such resources for some of our patients who might otherwise have been able to make such an adjustment. In addition, there were many patients with a diagnosis of nonpsychotic organic brain syndrome whose social impairment, even though they were not psychotic, required long-term compulsory residential care.

The operational criteria for admission to state hospitals have traditionally focused on the issue of psychosis and/or dangerousness. However, our data suggest that the determining factor in such decisions for the elderly should not be the presence or absence of psychosis. The ability to function—physically, mentally, and socially—is essential to maintaining oneself in the community. When functional ability is significantly impaired, institutional care is necessary. If the state hospitals will not care for these patients, a new institution must be created.

REFERENCES

1. The Elderly and Mental Health in New York State. New York, Community Service Society of New York Department of Public Affairs, 1965
2. Sillen J, Parker B, Feldshuh B, et al: A multidisciplinary geriatric unit for the psychiatrically impaired in Bellevue Hospital Center (unpublished)
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, second ed. Washington, DC, APA, 1968
4. Simon A, Cahan RB: The acute brain syndrome in geriatric patients, in Acute Psychotic Reaction, Psychiatric Research Report 16. Edited by Mendel WM, Epstein LJ. Washington, DC, American Psychiatric Association, May 1963, pp 8–21
5. Lowenthal MF, Berhman P, et al: Aging and Mental Disorder in San Francisco. San Francisco, Jossey-Bass, 1967
6. Lowenthal MF: Lives in Distress—the Path of the Elderly to the Psychiatric Ward. New York, Basic Books, 1964

The Effects of Social Prejudice on Hospitalized Adolescents

BY PAUL G. ROSSMAN, M.D., AND DEREK MILLER, M.D.

The authors describe an outbreak of intragroup prejudice on an adolescent service. The disturbance is traced to patient anxiety over prejudice against the mentally ill, as exemplified in a national event, the withdrawal of Sen. Thomas Eagleton as a candidate for Vice-President. The role of social prejudice as a source of anxiety and disturbed behavior within a hospital setting is stressed.

THE IDEA that hospital ward communities are closed social structures, impermeable to outside influences, has gradually declined over recent years. Many authors have written of the impact that society has on both the hospitalized patient and the ward milieu in which he lives. Goffman (1) described the manner in which a person who is emotionally disturbed has his identity transformed through hospitalization into that of a mental patient. He has detailed the numerous social consequences that follow such a transformation.

The authors are with the Adolescent Service, Neuropsychiatric Institute, University of Michigan Hospital, Ann Arbor, Mich. 48104, where Dr. Rossman is a resident and Dr. Miller is Professor and Chief.

The fact that people who carry the identity "mental patient" are often the objects of social prejudice is unquestioned. That such prejudice intrudes into the ward milieu of "closed" hospital systems is less well documented. Easson described several cases in which adolescent patients complained bitterly about prejudice directed toward them (2). What effect such social prejudice, the milieu in which they live, and their hospital course has on them was not specified. Similarly, Redl mentioned "seepage ingredients from the world outside," implying that no hospital ward milieu is free from the effects of its immediate social surroundings (3).

In outpatient adolescent treatment, pressure from social events clearly affects therapy issues (4). The purpose of this paper is to present clinical data to support the hypothesis that even in closed wards adolescent patients are particularly susceptible to prevailing social prejudices.

CASE REPORT

The adolescent unit of the Neuropsychiatric Institute of the University of Michigan is a semiclosed ward of 18 beds. The patients range in age from 13 to 17 and are evenly distributed between boys and girls. The majority of patients are aggressive, acting-out adolescents. The patients are usually seen in both individual and group treatment (the groups meet three times weekly). The counseling groups have coleaders, usually a psychiatric resident or a social worker and a nurse. The groups are either all girls or all boys, since we have found that mixed groups produce too much anxiety in hospitalized adolescents. The counseling discussions permit the patients to discuss issues that arise concerning life on the ward. Particular note is taken of patients' styles of relating to one another.

In July 1972 there was considerable social furor when a Vice-Presidential nominee, Sen. Thomas Eagleton, revealed a personal history of severe emotional illness. The press and other media detailed the candidate's past psychiatric history, including hospitalization and a course of electroconvulsive treatment. Subsequently, concerns about the nominee's capability as a potential Vice-President were raised. Surveys of public opinion indicated that significant numbers of people felt that a person with a background of emotional illness was unfit to be a Vice-Presidential candidate.

When the nominee later withdrew his name from the ballot, both staff and patients in the unit appeared superficially oblivious to the implications of the withdrawal. Although some staff members privately discussed the political import of this withdrawal, no one appeared to recognize that it might affect the patients, or that it could be a significant issue for them.

One week later, one of the girls' counseling groups spontaneously brought the issue up for discussion. The girls spoke of their concern that the candidate had been rejected because he had once been a mental patient; the consensus was that he had been treated unfairly. They further speculated about their own chances for success and survival when they left the hospital in the future. They imagined that they would be treated as second-class citizens and subjected to the kind of prejudice that was directed at the Vice-Presidential nominee. Although the group leaders often felt that it was difficult to sustain group discussion because of the girls' orientation toward action, interest in this social event was so intense that the meeting was extended spontaneously for the first time.

At the same time, in another group composed of adolescent boys, there was an outbreak of severe prejudice. In this racially mixed group several white patients referred to the black staff members as "niggers," broke into parodies of southern black drawls, and referred to some Jewish members of the group as "kikes." The group leaders were unable to understand this outbreak of prejudice in terms of the previous material with which the group had been struggling. Reviewing recent events on the ward itself similarly gave no clues. The data from the girls' group, however, offered a possibility. In the following session, the leaders interpreted the outbreak of prejudice as reflecting feelings in the group about the Eagleton affair. Several of the more prejudiced patients immediately acknowledged that they were deeply troubled about the affair and its effect upon their future position in society. The boys then expressed grave concern that the hospital would not assure confidentiality of their medical records. Loss of future employment opportunities or rejection from the military was the anticipated result. With the girls, they agreed that the candidate had been a victim of prejudice and expected that they too would encounter similar difficulties in the future. The boys appeared to be quite angry about the matter, feeling that they were the objects of considerable injustice.

DISCUSSION

The clinical vignettes reported here are drawn from group experiences on a ward for hospitalized adolescents. They suggest that "milieu seepage" can indeed be a profound stimulus for behavior on any psychiatric ward. The impact of this "milieu seepage stimulus" can be measured by the fact that it is very unusual for disturbed adolescents to be future-oriented (5).

Attempts to understand the group behavior as reflecting only the mores of the ward resulted in the leaders' initial failure to understand the origin of the boys' outbreak of prejudice. While some adolescents may be sufficiently verbal to state feelings openly, most disturbed adolescents communicate their feelings through action. In this case, the adolescent boys, feeling angry and helpless over their projected role as second-class citizens (a vision confirmed by the Eagleton affair), dealt with their anxiety by "identification with the aggressor." It is well known that people who are the object of prejudice are often particularly prejudiced themselves. The passive role is thus exchanged for an active one, and the unpleasant experience of being scorned is passed on to someone else (6). This unfortunate method of negative identification appeared to play a significant causative role in the outbreak of prejudice within the group.

These vignettes suggest that ward staff in both "closed" and "open" hospital settings need to be conscious of the prevailing issues of social importance. For example, many adolescent inpatients experience injuries to pride as a result of the hospitalization experience itself. Although its causes are many, this loss of self-esteem comes partly from the adolescent's concern for the immediate consequences of a new social identity as a mental patient. Significant news events that reflect social attitudes toward the mentally ill may then serve as a source of anxiety for hospitalized adolescents. When these news events transmit a social prejudice, as in the Eagleton af-

fair, disturbed behavior within the hospital setting may result.

REFERENCES

1. Goffman E: Asylums. New York, Doubleday, 1961
2. Easson W: The Severely Disturbed Adolescent. New York, International Universities Press, 1969
3. Redl F: The concept of a therapeutic community. Am J Orthopsychiatry 29:721–736, 1959
4. Szurek SA: Emotional health in adolescence, in Modern Perspectives in Adolescent Psychiatry. Edited by Howells JG. New York, Brunner/Mazel, 1971, pp 100–126
5. Miller D: The Psychology, Psychopathology, and Psychotherapy of Adolescents. New York, Jason Aronson (in press)
6. Freud A: Ego and the Mechanisms of Defense. New York, International Universities Press, 1966

Personality Characteristics of Servicemen Returned from Viet Nam Identified as Heroin Abusers

BY CAPT. PETER T. HAMPTON, MSC, USA, AND DONALD B. VOGEL, M.D.

The psychiatric characteristics of a sample of Army enlisted men returning from Viet Nam identified as heroin abusers were examined by means of psychological testing. Marked heterogeneity of psychological test types was noted. The four most common diagnostic classifications were normal, conduct disorder, abnormal but of indeterminate diagnosis, and psychosis. In comparison with studies describing civilian addicts, the results of this study suggest less psychopathology and a lower incidence of sociopathy in these military drug abusers.

OPINIONS ABOUT the psychological characteristics of servicemen in Viet Nam who are identified as heroin users vary markedly. On the one hand, there are the views that many are essentially normal individuals who used or became addicted to heroin because of the drug's ready availability in Viet Nam or because of the stresses inherent in a serviceman's tour of duty in Viet Nam. On the other hand is the view that, like many civilian addicts, they are predominantly disturbed individuals characterized particularly by antisocial and character disorder traits. This study is a preliminary attempt to delineate some of the psychiatric characteristics of Army servicemen identified as heroin abusers.

At the time this work was done, the authors were with the Mental Hygiene Consultation Service, U.S. Army Hospital, Fort Carson, Colo. 80913, where Capt. Hampton is Chief, Psychology Section, and Dr. Vogel was Chief, Psychiatry Service. Dr. Vogel is now with the Montgomery County Day Treatment Center of the Psychiatric Institute of Washington, Kensington, Md.

METHOD

The subjects were 101 enlisted men, ranging in age from 18 to 27, who were identified as heroin users by the urine analysis required of all military personnel leaving Viet Nam after the completion of their tour of duty there. These men were held for several days in Viet Nam for detoxification and were then air evacuated to the U.S. Army Hospital at Fort Carson, Colo., for further treatment and follow-up. Psychological testing with the Minnesota Multiphasic Personality Inventory (MMPI) was carried out to provide summary personality evaluations for this study. We tried to test all the servicemen sent to the hospital for drug abuse rehabilitation during the period September 1971 to April 1972. Unfortunately, some of these men were not tested, due mainly to a shortage of MMPI test booklets and a shortage of personnel to carry out the testing. Subjects were given the test by a psychiatric technician, usually on the first or second day after their arrival at the hospital.

The patients' test protocols were analyzed by Meehl's system of differential diagnosis (1). This system provides rules for analyzing the patient's test profile and first classifying it as psychiatrically normal, abnormal, or invalid. Those protocols classified as abnormal are then further sorted into the different diagnostic categories of psychosis, neurosis, or "conduct disorder." Since not all the abnormal profiles fit the rules for classification under one of these three categories, a fourth category of "abnormal, indeterminate" was employed for those which

TABLE 1
Subjects' MMPI Profile Classifications (N = 101)

Test Classification	Percentage of Subjects
Invalid	10
Normal	35
Conduct disorder	23
Psychosis	10
Neurosis	1
Abnormal, indeterminate	21

could not be more specifically classified. Profiles were also classified by two-digit code groupings, for which the two highest clinical scales on the individual profiles were selected (2).

RESULTS

Table 1 shows the percentage of subjects whose MMPI test protocols fell into each of the six classification categories. Overall, 55 percent of the protocols were judged to be psychiatrically abnormal, compared with 35 percent judged normal. Those with abnormal profiles were most frequently given a conduct disorder, psychosis, or indeterminate classification. Only one profile was classified as indicating neurosis.

Analysis by the two-digit code system revealed only two code types that occurred with any regularity. The 94 or 49 pattern was present in 17 percent of the profiles and the 98 or 89 pattern in seven percent. The 94 (49) pattern is generally considered indicative of character disorder or sociopathy and the 98 (89) of severe hypomania or schizophrenia (2, 3). The remaining 32 percent of the sample with deviant profiles exhibited 17 other distinct two-digit code types.

DISCUSSION

The results of this study suggest that a major proportion of servicemen who are identified as opiate users in Viet Nam can in fact be diagnosed as psychiatrically disturbed; however, they also suggest that a significant proportion may be relatively normal. The question of whether these military drug users are more psychiatrically disturbed as a group than other servicemen who do not use opiates cannot be answered by this study since there was no comparison group of servicemen who were not drug abusers. Other studies (4) investigating this issue have failed to identify personality characteristics that differentiate addicted servicemen from the general population of lower ranking enlisted men, and previous MMPI research with civilian drug abusers has demonstrated that, when a control group of nondrug abusers is also studied, the incidence of identified pathology is often fairly high in that group also (5, 6). Therefore, it cannot be safely assumed that the 55 percent abnormal figure from the present study might not also apply to non-drug-abusing enlisted men evaluated in the same manner.

A comparison of the characteristics of the military drug abusers studied here with the characteristics of civilian drug abusers seems to indicate less pathology in the military sample. Several MMPI studies (5, 7, 8) on civilian addicts report only four to 12 percent normal profiles as compared with the 35 percent normal profiles in the present study. Applying the classic addict stereotype of undifferentiated sociopathy to the military drug abusers appears unwarranted. More heterogeneity than homogeneity of test profiles was evident in the present study; and significant numbers of the drug-abuser group were identified as being psychiatrically normal, as psychotic, as having a conduct disorder, and as psychiatrically abnormal but of indeterminate diagnosis.

REFERENCES

1. Meehl PE: Profile analysis of the MMPI in differential diagnosis, in Basic Readings on the MMPI in Psychology and Medicine. Edited by Welsh GS, Dahlstrom WG. Minneapolis, University of Minnesota Press, 1956, pp 292–297
2. Dahlstrom WG, Welsh GS: An MMPI Handbook: A Guide to Use in Clinical Practice and Research. Minneapolis, University of Minnesota Press, 1960
3. Gilberstadt H: Comprehensive MMPI Code Book for Males. Minneapolis, Veterans Administration Hospital, 1970
4. Holloway HC: Profile of the military drug addict. Read at the Drug Abuse Training Institute for the Military, San Antonio, Tex, Oct 31–Nov 3, 1971
5. Gilbert JG, Lombardi DN: Personality characteristics of young male narcotic addicts. J Consult Psychol 31:536–538, 1967
6. Smart RG, Jones D: Illicit LSD users: their personality characteristics and psychopathology. J Abnorm Psychol 75:286–292, 1970
7. Hill HE, Haertzen CA, Glaser R: Personality characteristics of narcotic addicts as indicated by the MMPI. J Gen Psychol 62:127–139, 1960
8. Sutker PB: Personality differences and sociopathy in heroin addicts and nonaddict prisoners. J Abnorm Psychol 78:247–251, 1971

An Overview of a Psychiatric Clinic Population

BY PETER E. SIFNEOS, M.D.

The author describes a set of criteria designed as guidelines in the evaluation of persons who apply for treatment at a psychiatric clinic. The main focus in this paper is on determining which patients are good candidates for short-term anxiety-provoking psychotherapy, but it is hoped that this will lead to the establishment of selection criteria for a variety of therapeutic techniques.

A DETAILED AND QUALITATIVE STUDY of the people who make up a psychiatric clinic population offers the opportunity to understand better those individuals who at times of stress develop emotional crises and seek psychiatric help for their psychological difficulties. In addition, only a systematic selection procedure of appropriate candidates according to specified criteria, a description of various kinds of psychotherapeutic techniques, and a presentation of the results that have been obtained will provide the necessary conditions for meaningful research on the efficacy of these various kinds of psychotherapy of shorter or longer duration (1).

Statistical data on age, sex, marital status, and occupation, which are ordinarily used to describe a clinic population, give only a superficial impression of the individual patients, while a very detailed case presentation, interesting though it may be, fails to characterize the whole group.

It should be emphasized from the start that this paper will present an overview of the people who come to the Psychiatric Clinic of the Beth Israel Hospital in Boston. For better or for worse, its population is not balanced in terms of race, ethnic group, age, sex, or education. We have no catchment area. After evaluating each patient intensively and attempting to understand the reasons underlying his emotional difficulties, we arrive at a decision as to what in our opinion is the best way to deal with his problems and we communicate our recommendations to him. If the treatment indicated is available in our clinic, we accept the patient and treat him accordingly. If on the other hand it is not, as is the case with outpatient electroshock treatment or psychoanalysis, we refer the patient to those institutions which can provide such treatment.

It should be made clear, however, that we do not select our patients on the basis of their needs. The heroin addict demands heroin and the anxious neurotic verbalizes his need for medication to alleviate his discomfort. Despite these needs, however, we do not give heroin to the addict, nor do we give chlorpromazine to the anxious neurotic, since it will eliminate his anxiety and perpetuate its raison d'être. Thus we do not offer psychotherapy, even if the patient asks for it, when in our opinion it is contraindicated, and many times it is.

In this paper, then, I shall describe a set of criteria that have been designed to evaluate the organization of our patients' personalities and their overall strengths and weaknesses and to help us with the selection procedure. Furthermore, these criteria are basic requirements for any psychiatric evaluation because they predetermine the appropriate psychological treatment that is best suited to each individual patient. They are being used at the present time as guidelines in the evaluation of all those who come to our psychiatric clinic. In this report, I shall include the findings on 182 patients who were seen between July 1970 and January 1971.

EVALUATION CRITERIA

A forced-choice questionnaire (see appendix 1) was filled out by 40 clinic evaluators; these included third-year psychiatric residents, social workers, psychologists, senior psychiatrists, and the director of the clinic.

The first criterion attempts to scrutinize the patient's ability to circumscribe and to choose out of a variety of complaints the one that, in his opinion, is most important and requires immediate attention. This ability to concentrate on a specific area of emotional difficulties demonstrates strength of character and is considered essential for the solution of the patient's emotional problem. It is also an important prognostic criterion for the ultimate success of dynamic psychotherapy of short duration.

The patient who has experienced during his lifetime at least one "meaningful" or give-and-take type of relationship with another person has demonstrated a capacity to deal with the vicissitudes and the realities of everyday life. An opportunity is provided during the psychiatric evaluation interview to assess the patient's ability to relate to other people by scrutinizing the ways in which he interacts with the evaluator and to observe whether he has access to his emotions and whether or not he is able to express them appropriately. An above-average intelligence that includes some evidence of flexibility is also a requirement for psychotherapy in general, and an effort

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Sifneos is Associate Director, Department of Psychiatry, Beth Israel Hospital, 330 Brookline Ave., Boston, Mass. 02215, and Associate Clinical Professor of Psychiatry, Harvard Medical School, Boston.

TABLE 1
Summary of Evaluations of 182 Patients

Category		Number
Part A		
1.	Specific chief complaint	98
2.	History of at least one meaningful relationship	132
3.	Ability to interact with evaluator	149
4.	Above-average intelligence	147
5.	Motivation for change:	
	Excellent score 7	59
	Good score 6	25
	Fair score 5	23
	Questionable score 4	22
	Unmotivated score 3–0	53
Part B		
6.	Adequate self-esteem	95
7.	Ability to solve emotional problems	58
8.	Self-understanding	84
9.	Emotional crisis	79
10.	External stress	83

should be made by the evaluators to arrive at a rough estimate of the patient's IQ.

In our experience the patient's "motivation for change" is the most important prognostic criterion for the ultimate success of dynamic psychotherapy (2) and a very special effort should be made to assess it carefully. For this reason, we use seven additional criteria to evaluate motivation. The patient must be able to recognize that his symptoms are psychological in origin. He must be introspective, honest in reporting about himself, and interested in participating actively in treatment. In addition, he should be curious and he must be willing to change and make reasonable sacrifices. Finally, his expectations about the results of the treatment must be predominantly realistic.

In a recent review we found that 163 patients, or about 50 percent of all patients who were evaluated in our psychiatric clinic during 1969–1970, scored 6 or 7 on a seven-point scale, which demonstrated that their motivation for change was considered to be "good" or "excellent" (3). Furthermore, it was of interest to note that the patients' motivation increased during the early part of dynamic psychotherapy, signifying that the treatment was proceeding well and that an eventual successful outcome was anticipated (3).

Patients who fulfill all five criteria in Part A are considered to be good candidates to receive anxiety-provoking psychotherapy—a special kind of dynamic psychotherapy of short duration in which our clinic specializes, the results of which are currently being investigated systematically by a controlled research study.

Under Part B of our questionnaire are listed five additional criteria. The first three are designed to assess the state of the patient's self-esteem, his ability to solve his emotional problem, and his capacity to understand himself. These three factors have been found to have played an important role in the successful treatment of patients who were seen in follow-up interviews.

We are also interested in seeing whether the patient at the time of his evaluation was in a state of "emotional crisis," which is viewed as "a turning point for better or for worse," and whether he was under the impact of realistic external stress that would tend to put additional pressure on him and to create complications in his psychotherapy.

FINDINGS

Over a period of six months, from July 1970 to January 1971, 182 patients were evaluated. Women outnumbered men by a ratio of 2:1 and the patients' ages ranged from 18 to 65 years. By far the majority of the patients (76 percent) were between 20 and 30 years old, and more than half were single. Forty-two percent were full-time students, but many others, who were listed under a different occupational category, were taking day or night courses or were involved in some kind of educational activity. Other occupations included aides, technicians, or clerks (13 percent). Social workers, "unemployed," and "miscellaneous" constituted ten percent each and housewives, secretaries, and teachers constituted approximately five percent each.

Looking now at the first five selection criteria in Part A of our questionnaire (table 1), we discovered that more than half of the patients demonstrated an ability to circumscribe their complaints. Approximately 73 percent gave a history of one meaningful relationship with another person, 82 percent were able to interact with the evaluator and experience some kind of emotion during the interview, and about 81 percent were considered to be of above-average intelligence. Eighty-four persons, or 46 percent of the total, showed "good" to "excellent" motivation for change (score 6 or 7 on our seven-point motivation scale). This figure is slightly lower than the 50 percent noted in a similar sampling of the patients' motivation during 1969–1970. Twenty-nine percent were considered unmotivated (score 3 to 0) in both the 1969–1970 sampling and in our present study.

A total of 47 patients fulfilled all five criteria in Part A. In 38 of these the motivation was "excellent" (score 7), while in nine it was "good" (score 6). Since the fulfillment of these criteria is a prerequisite for the selection of patients to receive short-term anxiety-provoking psychotherapy, it is of interest to see that one-quarter of our clinic patients are good candidates for this treatment. Thus, on the basis of our previous work, we could predict with some degree of certainty that if these 47 patients were offered short-term anxiety-provoking psychotherapy, their chances for improvement were considered to be excellent (4). Furthermore, because it is necessary during the course of this kind of psychotherapy to concentrate on a specific area of emotional difficulties in order to solve the underlying emotional problem, we were interested in seeing how many additional patients who fulfilled only our first criterion (ability to circumscribe their chief complaint) were also highly motivated to change,

fulfilling the fifth criterion with a score of 6 or 7. Ten additional patients fell into this category.

The findings involving the criteria in Part B are also shown in table 1. Of the 47 patients who fulfilled all five criteria in Part A, 38 fulfilled one or more of the first three criteria in Part B. Twenty patients with "excellent" motivation (score 7) and two patients with "good" motivation (score 6) also fulfilled the sixth, seventh, and eighth criteria in Part B. Nine patients with "excellent" motivation showed both adequate self-esteem and evidence of self-understanding. One patient with "excellent" motivation and three patients with "good" motivation showed adequate self-esteem and three patients with "excellent" motivation showed evidence of self-understanding.

When the ten patients who fulfilled the first and fifth criteria in Part A are examined in a similar way, six additional patients may be added, bringing the total to 44. One of these demonstrated adequate self-esteem and showed an ability to solve his emotional problem and to understand himself. Two patients showed both problem-solving ability and self-understanding and two more only adequate self-esteem. Finally, one demonstrated only self-understanding. In addition, out of these 57 highly motivated patients, 28 were considered to be under the influence of external stress (criterion 10 in Part B). Of the 53 patients who were considered unmotivated (motivation score of 3 to 0), 22 were also under external stress. Thus, external pressures appeared to be almost evenly divided between the unmotivated and the motivated groups.

CONCLUSIONS

We are continuing to correlate these various criteria but our findings will not be presented in this paper. We do hope, however, that this will lead to the establishment of different selection criteria for a variety of psychotherapeutic techniques. It appears to be possible not only to survey the whole population of a psychiatric clinic in depth, using sophisticated criteria, but also to select the candidates for whom a specialized kind of short-term psychotherapy is appropriate.

REFERENCES

1. Sifneos PE: Short-Term Psychotherapy and Emotional Crisis. Cambridge, Mass, Harvard University Press, 1972
2. Sifneos PE: The "motivation process": a selection and prognostic criterion for psychotherapy of short duration. Psychiatr Q 42:271–280, 1968
3. Sifneos PE: Change in patients' motivation for psychotherapy. Am J Psychiatry 128:718–721, 1971
4. Sifneos PE: Learning to solve emotional problems: a controlled study of short-term anxiety-provoking psychotherapy, in The Role of Learning in Psychotherapy. Edited by Porter R. London, J&A Churchill, 1968, pp 87–100

APPENDIX 1

Criteria for Selection of Patients for Psychotherapy
Beth Israel Hospital Psychiatric Clinic

Patient's Name_____ Evaluation no._____
Age____ Sex____ Marital status____ Occupation_____
Interviewer_____ Date_____
Type of interview (check one): ____ evaluative
____ administrative
____ research

	(Check only one) YES	NO
PART A		
1. Can the patient circumscribe his difficulties?		
a. Is the chief complaint specific?	____	____
b. Is it anxiety, depression, conversion, phobia, obsession, compulsion, other_____?	____	____
2. Is there a history of at least one *meaningful* relationship (give-and-take, altruistic, etc.) with another person?	____	____
3. Can the patient interact with the evaluator by experiencing some emotion during this interview?	____	____
a. Is the emotion fear, anxiety, anger, sadness, joy, happiness, elation? _____		
b. Is there evidence of tension, nervousness, frustration? _____		
4. Is the patient of above-average intelligence?	____	____
5. Motivation for change—does the patient show:		
a. Ability to recognize that symptoms are psychological?	____	____
b. Introspection and honesty in reporting about himself?	____	____
c. Willingness to participate actively in treatment?	____	____
d. Active curiosity about himself?	____	____
e. Desire to change?	____	____
f. Realistic expectations of results?	____	____
g. Willingness to make reasonable sacrifices?	____	____
Score for motivation for change ____		
PART B		
6. Does the patient show adequate self-esteem?	____	____
7. Is he able to solve his emotional problem?	____	____
8. Is he able to understand himself?	____	____
9. Is he in a state of emotional crisis?	____	____
10. Is he under the influence of external stress?	____	____

Metapsychiatry: The Interface Between Psychiatry and Mysticism

BY STANLEY R. DEAN, M.D.

After giving some historical background on psychic phenomena, including research on this subject by psychiatrists, the author sets forth ten distinguishing characteristics of the "ultraconscious summit." He suggests that if clinicians encourage patients to disclose any paranormal experiences and if data on these are collected and analyzed, then a rational breakthrough in this area might well occur.

"METAPSYCHIATRY" IS A TERM I have proposed to designate the important interface between psychiatry and mysticism. Metapsychiatry includes not only parapsychology but also all other suprasensory and suprarational manifestations of human consciousness that are in any way relevant to psychiatry (1).

Psychic research is a legitimate concern of psychiatry, the specialty best qualified to investigate phenomena, assess validity, and expose fallacy in matters of the mind. There can be little doubt that reciprocal enlightenment would result if psychiatry lent its expertise to the religious and philosophic speculations by which it has hitherto been preempted. Psychiatry can even take special pride in becoming involved, for Dr. Richard Maurice Bucke, in 1890 the president of APA's parent organization, the American Medico-Psychological Association, was a distinguished pioneer in the field. In May 1894, he read a paper entitled "Cosmic Consciousness" at the annual meeting of that society in Philadelphia.

Four years later he published a book under the same title (2). In it he developed the theory that a seemingly miraculous higher consciousness, appearing sporadically throughout the ages, was a natural rather than an occult phenomenon, that it was latent in all of us, and was, in fact, an evolutionary process that would eventually raise all mankind to a higher level of existence. Dr. Bucke was ahead of his time, but his book is being rediscovered and acclaimed.

Cosmic consciousness refers to a suprasensory, suprarational level of mental activity that transcends all other human experience and creates a sense of one-ness with the universe. Its existence has been known since antiquity under a variety of regional and ritualistic terms—*nirvana, satori, samadhi, kairos, unio mystica*, to name but a few. For purposes of standardization I have proposed the term "ultraconsciousness" to provide a semantic tie to current psychiatric terminology (3).

Miraculous powers have been attributed to the ultraconscious, and from it have sprung the highest creativity and loftiest ideals known to man. Yet it remains one of the great enigmas of the mind. All but neglected by scientific research in the past, despite the paradoxical fact that even scientists embrace it in religion, it has in recent years attracted increasing interest for a number of reasons. Accelerated communication and travel have forged closer transcultural links between Western empiricism and Eastern mysticism; computer technology has made available vast reservoirs of integrated data (e.g., the Central Premonitions Registry, Box 482, Times Square Station, New York, N.Y. 10036); space exploration has ushered in an enormous awareness of the universe, and with it a corresponding desire to expand the horizons of consciousness; psychedelic drugs, their uses and abuses, have dramatically focused attention upon extraordinary levels of consciousness; and people who are increasingly disillusioned by the inability of modern technology to stem the tides of war, crime, intolerance, poverty, and pollution seek new avenues of universal harmony.

Some countries have already risen to the challenge. A recent best seller reports large-scale government-sponsored research in Soviet countries that has allegedly resulted in some startling psychic discoveries (4). One, with far-reaching political and paramilitary implications, deals with the possibility of influencing human behavior ("brainwashing") and even matter (psychokinesis) by telepathic remote control. Another—of special interest to space exploration—alludes to instant telepathic communication over immense distances via theoretical units of thought, called tachyons.

There have even been attempts to explain supernatural religious beliefs on a scientific basis. For example, a special high-frequency photographic technique, known after its Russian proponents as the "Kirlian effect" (5), has allegedly revealed luminous pulsating energy waves that are emitted into the atmosphere by all forms of life; these waves presumably intermingle and interact with other emanations, past, present, and future, and can theoretically be detected by properly developed human and mechanical sensors. Thelma Moss and her coworkers at the University of California, Los Angeles, have succeeded in taking similar photographs (6). The question naturally arises whether such emanations correspond to the religious conceptions of the soul and, in turn, lend credence to the claims of gifted psychics that they are

Read at a panel at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Dean is Clinical Professor of Psychiatry, University of Florida College of Medicine, Gainesville, and University of Miami Medical School, Fla. Address reprint requests to 2121 North Bayshore Drive, Miami, Fla. 33137.

able to "tune into" the emanations of other souls and cure sickness by the laying on of hands, to give two examples. If so, the human mind could be regarded as a super-sensitive receiver that is capable, in its highest development, of tuning into the innermost channels of the universe.

Such reports have excited interest and concern the world over. There is certainly an urgent need for the United States government to initiate similar research. It probably has considerable awareness of the problem already. The Army's intelligence agency, for instance, discussed the power of mental telepathy in a manual published by the Technical Bulletin Department of the Provost Marshal General's office entitled *Techniques of Surveillance and Undercover Investigation* (7).

DESCRIPTION OF THE ULTRACONSCIOUS

It seems strange that I should have become involved in psychic matters, for my orientation is decidedly pragmatic, and I have never experienced any ultraconscious manifestation stronger than an occasional flash of intuition, common to all of us. However, that may be all to the good, for it enables me to approach the subject with an unbiased attitude.

My interest was first aroused by a chance encounter with a Zen master in Tokyo, then by subsequent observation and filming of Zen Buddhist rituals during several visits to Japan (8) and also by interviews with several so-called "sensitives" or "psychics." I was impressed to find that great numbers of sensible, rational people in all walks of life, lay and professional, believed in the ultraconscious, had themselves experienced various manifestations of it, and had derived constructive benefit from it. We psychiatrists are conditioned to equate hallucinations with schizophrenia and other psychoses, but a great many nonpsychotic individuals also hear voices, see visions, and have other supernatural experiences. I am currently conducting intensive psychiatric evaluations on a series of such individuals in order to obtain a factual determination of their mental and emotional status.[1] As a physician I am particularly interested in any healing factors that clinical development of the ultraconscious may contribute to psychotherapy.

The ultraconscious summit, though rare, produces a superhuman transmutation that defies description. The mind, divinely intoxicated, literally reels and trips over itself, groping for words of sufficient exaltation to portray the experience. As yet, we have no such words. One cannot help but wonder if it is analogous to erotic love. Gopi Krishna believes that the ultraconscious (which he calls "Kundalini") is, in fact, a highly evolved transmutation of sex vitality (9).

To begin with, there are many *formes frustes* of the ultraconscious spectrum: they vary greatly in frequency, intensity, and duration in different persons and even in the same person at different times. They may occur at any time, awake or asleep, spontaneously or only after long years of arduous discipline.

From the welter of literature and liturgy, ancient and modern, I have summarized ten distinguishing characteristics of the ultraconscious summit:

1. The onset is ushered in by an awareness of light that floods the brain and fills the mind. In the East it is called the "Brahmic splendor." Walt Whitman speaks of it as ineffable light—"light rare, untellable, lighting the very light—beyond all signs, descriptions, languages" (10). Dante writes that it is capable of transhumanizing a man into a god and gives a moving description of it in lines of mystical incandescence from "Paradiso" of the *Divine Comedy* (11).
2. The individual is bathed in emotions of supercharged joy, rapture, triumph, grandeur, reverential awe, and wonder—an ecstasy so overwhelming that it seems little less than a sort of superpsychic orgasm.
3. A noetic illumination that is quite impossible to describe occurs. In an intuitive flash one has an awareness of the meaning and drift of the universe, an identification and merging with creation, infinity, and immortality, a depth beyond revealed meaning—in short, a conception of an "Over-Self," so omnipotent that religion has interpreted it as God.
4. There is a feeling of transcendental love and compassion for all living things.
5. Fear of death falls off like a mantle; physical and mental suffering vanish. There is an enhancement of mental and physical vigor and activity, a rejuvenation and prolongation of life. This property should command the special interest of psychiatry and medicine.
6. There is a reappraisal of the material things in life, an enhanced appreciation of beauty.
7. There is an extraordinary quickening of the intellect, an uncovering of latent genius and leadership.
8. There is a sense of mission. The revelation is so moving and profound that the individual is moved to share it with his fellowmen.
9. A charismatic change occurs in personality—an inner and outer radiance takes over, as if the person is charged with some divinely inspired power, a magnetic force that attracts and inspires others.
10. There is a sudden or gradual development of extraordinary perception, telepathy, precognition, or healing. Though generally regarded as occult, such phenomena may have a more rational explanation; they may be due to an awakening of the transhuman powers of perception latent in all of us.

DISCUSSION

The ultraconscious summit is a genuine metamorphosis of consciousness that has been experienced by certain sages, prophets, leaders, and men of genius through the ages. The factors producing it are as yet unknown, but the remarkable uniformity of distinguishing charac-

[1] This study is partially supported by a grant from the Academy of Parapsychology, Healing, and Psychic Sciences.

teristics should leave no doubt that a common denominator—empirically validated if not yet scientifically proven—underlies all of them. It is only a matter of time before science dissociates it from religious dogma and explains it to the satisfaction of the intellect in terms of naturalistic laws.

As ontogeny recapitulates phylogeny, so may the human mind be a microcosm that recapitulates the evolution of the universe, or so may "psychogeny recapitulate cosmogeny." This theory presupposes that the rudiments of the ultraconscious are present in all and can be prematurely awakened in some. If to do so would make a better world, then science will not long delay accepting the challenge.

Fortunately, there is no dearth of material. Though total ultraconsciousness is rare, a great variety of lesser manifestations exists in abundance. While the scientist studies them in his laboratory, the enlightened clinician can observe them in his practice. A simple first step would be to encourage people to disclose any paranormal ("supernatural") experiences and to treat such disclosures with an open-minded, noncynical attitude. The clinician will be amazed at the abundant material he can thus elicit. And if the resulting data from laboratory and clinic were collected, pooled, and analyzed, it could not help but result in rational breakthroughs.

Despite my lack of psychic powers, I can envision a tremendous upsurge in psychic research, with and without government support, in the near future. Is that clairvoyance or common sense? Perhaps the two are not so different after all.

REFERENCES

1. Dean SR: Metapsychiatry and the ultraconscious. Am J Psychiatry 128:154–155, 1971
2. Bucke RM: Cosmic Consciousness, 22nd ed. New York, EP Dutton & Co, 1964
3. Dean SR: Beyond the unconscious: the ultraconscious. Am J Psychiatry 122:471, 1965
4. Ostrander S, Schroeder L: Psychic Discoveries Behind the Iron Curtain. New York, Bantam Books, 1971
5. Kirlian SD, Kirlian VCh: Photography and visual observations by means of high-frequency currents. Journal of Scientific and Descriptive Photography (USSR) 6:397–403, 1961
6. Moss T, Johnson K, Chang AF: Effects of alcoholic consumption in people as observed through electrical field photography (unpublished)
7. Norman EH: Beyond the Strange. New York, Popular Library, 1972, p 151
8. Dean SR: Is there an ultraconsciousness beyond the unconscious? Can Psychiatr Assoc J 15:57–62, 1970
9. Krishna G: Kundalini, the Evolutionary Energy in Man. Berkeley, Shambala Publications, 1971
10. Whitman W: Prayer of Columbus, in Leaves of Grass. Philadelphia, David McKay, 1891, p 323
11. Dante A: Paradiso, in The Divine Comedy. Translated by Longfellow HW. Boston, Houghton Mifflin Co, 1913

How Success Nearly Wrecked a Residency Experience

BY FRANK M. KLINE, M.D.

The number of residents in a second-year program increased almost threefold between 1965 and 1971. Total patient visits increased by almost 100 percent. However, the average number of monthly patient visits per resident decreased, indicating a loss of efficiency. After discussing how the clinic dealt with this problem, the author concludes that increases of this magnitude require the addition of more supervising psychiatrists, changes in administrative style, and adequate clerical assistance and space.

THE SECOND-YEAR RESIDENCY PROGRAM at Los Angeles County-University of Southern California Medical Center expanded from nine residents in 1965 to 23 in 1971. During the same period, the total number of patient visits increased from 21,005 to 41,789. While this may look like success, it turned out that the average monthly number of patient visits per resident decreased. Two full-time supervising psychiatrists, additional office space, changes in administration, and other factors reversed this trend in 1970. Numbers may not be the only or the major indicator of "success," but they are one factor to consider (1, 2).

Dr. Kline is Associate Director, Adult Psychiatric Outpatient Clinic, Los Angeles County-University of Southern California Medical Center, 1237 North Mission Rd., Los Angeles, Calif. 90033, and Assistant Professor of Psychiatry, University of Southern California School of Medicine.

TABLE 1
Changes in Numbers of Residents and Patient Utilization (1965–1971)

Year	Number of Second-Year Residents	Total Patient Visits	Average Patient Visits per Month per Resident
1965	9	21,005	194.5
1966	12	25,275	175.5
1967	13	27,849	178.5
1968	17	27,475	134.7
1969	23	30,370	110.0
1970	21	36,474	114.7
1971	23	41,789	151.4

HISTORY

In 1959 the current director assumed his duties and found four second-year psychiatric residents and a few excellent volunteer supervisors. Over the years a new staff was developed with 30 highly qualified volunteer physician supervisors; five psychiatric social workers; three full-time, two half-time, and six quarter-time psychiatrists; a psychologist; a clinic nurse; a full-time pharmacist; and 23 residents. The clinic gained the community's respect and referrals from other services increased. The residency program gained in reputation because of the staff's wide clinical experience, the quality of supervision, and high salaries. The increase in the number of residents, the reputation of the clinic, and the successful efforts of the director to reduce the waiting time produced a gradually expanding patient load. A major crisis that was precipitated by insufficient office space occurred in 1968.

OBSERVATIONS

Table 1 shows the number of second-year residents for each year from 1965 to 1971—there was an increase from nine in 1965 to 23 in 1969—and in the yearly total patient visits for the same period. The total patient visits show an impressive increase from 21,005 in 1965 to 41,789 in 1971. The total number of patient visits includes patients seen by staff members, third-year residents, and other students. These account for 20 percent of the total. The number of residents more than doubled, while the total number of patient visits did not.

Table 1 also shows the average number of patient visits per month per resident. This figure does not represent the actual number of visits, but is obtained by dividing the total patient visits by the number of residents times 12. Since this does not take into account the 20 percent of patients seen by other staff members, the actual number of patient visits per month per resident would be about 20 percent lower than the figure shown in table 1.

The table shows that increasing the number of residents in training does not automatically increase either the total number of patient visits or the average number of patient visits per month per resident. Even additional staff may not help. For example, in 1968, the number of residents increased from 13 to 17. There was an additional full-time supervisor, but there was a decrease in total patient visits from 27,849 to 27,475. More surprising, the average patient visits fell from its 1965 level of 194.5 to 110 in 1969 as the number of residents increased from 9 to 23.

DISCUSSION

What happened was that the number of residents increased rapidly without a preceding change in administrative structure, the number of full-time staff and volunteer supervisors, adequate office space, auxiliary personnel, and number of patients.

By 1968, 17 residents and staff members were sharing space designed for two-thirds that number. Like Norwegian rats under crowded conditions, staff members were at each other's throats. Energy that should have gone to research training and patient care was dissipated in intra-office conflict (3). Residents and social workers argued over who was more important and, therefore, who was entitled to full-time versus half-time use of offices. The residents also complained to staff that "they were here to learn, not to treat." While this appeared to be an educational issue, it seemed related to the fact there was not enough office space in which to see patients and, therefore, the importance of clinical experience was denied. It also seemed that, for the residents to be helpful and caring toward patients, they had to feel cared for themselves.

Even the clinic director's six- by eight-foot office was shared with the clinic secretary, who left before the end of the year. Without secretarial help, our problems were compounded.

Other critical factors were an administrative structure designed for ten residents and an insufficient number of experienced paid and volunteer psychiatric supervisors. The one highly capable, qualified, experienced full-time supervisor was overwhelmed by the sheer volume of work. Though a second full-time supervisor was added in November 1968 and a third in July 1969, the new clinic building with sufficient office space was not finished until 1970. By then we had two very capable secretaries and there had been a change in administrative procedure. Each full-time supervising psychiatrist now had responsibility for one-third of the residents and one-third of the program. This made it possible to monitor the administrative problems, work load, and work quality of each resident. All initial write-ups were read and this enabled staff members to block inappropriate referrals to outside clinics and agencies. All this did not immediately affect the average number of patient visits, but a year later (1970) there was an increase from 110 to 144.7 and a further increase to 151.4 in 1971.

We think the reversal occurred because of changes in administrative style, increased office space, additional full-time psychiatric supervisors, and the passage of time required to season new supervisors and programs.

Equally important was the increased number and seasoning of volunteer supervisors and secretaries.

We are not trying to suggest that individual work volume is the only measure of residency training. We are acutely aware that nearly 200 patient visits per month (such as we had in 1965) may represent an overemphasis on clinical service that limits time for reading and seminars. But it is interesting that the year the residents complained most about "excessive" service obligations was the year they saw the fewest patients. If we deduct the 20 percent of patients seen by nonresidents, each resident averaged 160 patient visits per month; since each resident sees an average of 40 patients per month in group therapy, individual patient visits were actually 120. This seems an excessive load in a training program. On the other hand, 110 patient visits per month (such as we had in 1969) or 48, if we deduct the 20 percent seen by others and the 40 patients seen in groups, does not provide a sufficient clinical base for learning. This is too limited an experience in individual psychotherapy. It is our impression that a more extensive clinical experience with individual patients is necessary for resident training and development.

This was obviously not a controlled experiment, but it appears that a rapid increase in mental health professionals without a preceding increase in administrative structure lowers individual effectiveness. More bodies produce more work, but the increase is not proportional. In fact, a gross oversupply may even decrease the total number of patient visits. Even additional office space and supervisors will not immediately reverse the downward trend. In our experience, one year was needed before the addition of supervisors, office space, and changes in administrative style brought about an increase in the average number of patient visits.

CONCLUSIONS

A training program should provide at least one office per resident and staff member, a sufficient number of full-time supervising psychiatrists (one per seven residents), six to seven hours of individual and group supervision per resident per week, a reasonable administrative structure, and adequate secretarial and clerical help. Without these, individual efficiency is lowered. As programs enlarge, there are problems in morale that may cause bitter infighting between individuals and disciplines, and training suffers.

Enlarging a second-year training program from nine to 23 residents requires additional supervising psychiatrists and changes in administrative style. It is not possible to run a 23-resident program on an informal basis. Formal, even written, structure is imperative; consultation among staff members is no longer a luxury, but a necessity. It is also apparent that additions in supervising staff and office space are not immediately reflected by comparable increases in the average number of patient visits. There is a lead time of one or more years. Psychiatric residents first need to be "housed, fed, and cared for"; then they are able to "feed and care for" patients.

REFERENCES

1. Lipscomb CF: The Yorktown psychiatric center: a five-year review. Am J Psychiatry 127:232–237, 1970
2. Lipscomb CF: An attempt to study time utilization in a mental health program. Am J Psychiatry 129:82–84, 1972
3. Carey GW: Density, crowding, stress, and the ghetto. Am Behav Sci 15:495–509, 1972

LETTERS TO THE EDITOR

"Dying with Their Rights On"

SIR: The old medical school saw of "dying in electrolyte balance" is not easily forgotten. Each of us remembers the compulsive chemo-clinician who, preoccupied solely with the patient's sodium, calcium, magnesium, potassium, and a host of other electrolyte levels, scarcely noticed the patient slowly slipping away. Even though the patient died, the fact that he was in perfect electrolyte balance when it happened was some sort of morbid clinical triumph.

This not-see-the-forest type of vision has now permeated psychiatry. In the zeal to impeccably protect the patient's civil liberties and rights, an increasing number of troubled and psychotic patients are what I choose to term dying with their rights on. I would venture that this also represents some sort of morbid clinico-legal triumph.

Three such cases have come to my attention here in Wisconsin during the past seven months since a federal court decision (*Lessard vs. Schmidt*) declared the state's commitment laws unconstitutional and prescribed a new, sole definition of committability. This definition is: "extreme *likelihood* that if the person is not confined he will do *immediate* harm to himself or others." Under this law, a 49-year-old anorexic woman starved herself to death; a 70-year-old man died a self-perpetuating, metabolic, toxic death; and a 19-year-old student, while unable to qualify for commitment under the new guidelines, was able to hang herself.

Each of these patients needed commitment; none qualified. Each outcome was entirely predictable. Each of these patients went to his or her grave with his rights entirely intact. (A similar case of a woman who "died after her civil rights were inviolably observed" was reported in *Psychiatric News* [1].)

The purpose of this letter is to solicit from the readers of the *Journal* similar cases so that they can be properly weighed in a central collection rather than by sporadic or anecdotal reports. The delicate task of balancing humane concerns with legal concerns in the commitment process is a legitimate concern of psychiatry. Certainly the right of the psychiatric patient to be free is a precious and important one, yet even that right must be reasonably weighed against the right of the patient and those around him to be protected from tragic and serious untoward effects of the patient's illness. The right to be protected has recently been overshadowed by our concern about the right to be free. *Both* are important. It seems to me that if there is a right to drown, for example, there must also be a right to be rescued.

Persons concerned with the patient's right to be sick and free have been more vocal and persuasive recently as the perpetual pendulum has swung from frank paternalism to frank abandonment; both of these extremes are distasteful. Now the voice of those who have seen cases in which the patient's rights but not his life were protected need to be heard also. A collection will speak more loudly than isolated instances. There must somehow be a proper balance between these two rights to prevent the several kinds of injustices possible.

Would any reader of the *Journal* who has knowledge of such cases please send them to me at the address below.

REFERENCE

1. Hodge P: A troubled life and a violent death. Psychiatric News, March 21, 1973, pp 1, 31

DAROLD A. TREFFERT, M.D.
Superintendent
Winnebago State Hospital
Winnebago, Wis. 54985

Are Methadone Withdrawal Patients Overprotected?

SIR: In working with heroin addicts who have subsequently entered a methadone maintenance program, I have seen the great physical difficulty patients have in withdrawing from methadone. Many of their symptoms seem to last for weeks after the initial withdrawal. For this reason, among others, many addicts are returned to the maintenance programs. It has been suggested that the abrupt withdrawal of methadone does not produce the excruciating subjective and objective symptoms usually associated with heroin withdrawal (1). Isbell and associates (2) described only mild withdrawal effects after abrupt cessation of methadone dosages higher than those now in clinical use. The fact that prolonged withdrawal from methadone causes as much discomfort as it does raises many questions.

Recently three patients who had had difficulty withdrawing from methadone gradually in outpatient and inpatient facilities were incarcerated. The jail authorities permitted methadone to be administered to these men, but it was withdrawn over a few weeks' time (about 30 days). Although none of the men knew of the others' experiences, all three had a similar response in that their symptoms upon withdrawal were minimal compared with previous withdrawals. They were in a situation where the anticipation of getting drugs was eliminated (obtaining hard drugs in a county jail is obviously difficult). The case reports of the young men follow:

Case 1. This 21-year-old white man with a two-year history of heroin addiction had been withdrawn twice previously on 30-day methadone programs. Each time marked symptoms of withdrawal began when he reached the dosage level of 15–20 mg.: he appeared pale and agitated and complained of insomnia, anorexia, and abdominal cramping. On one occasion he was hospitalized for withdrawal symptoms; they had become so severe that large doses of haloperidol (Haldol) and other sedatives did not relieve his insomnia and other symptoms. He was then placed in a methadone maintenance program for six months, receiving doses of approximately 120–150 mg. per day during this period.

While incarcerated, he was withdrawn from 120 mg. of methadone per day over a one-month period. A follow-up visit to my

office revealed that his insomnia had lasted only a few nights while he was in jail. In general, he was surprised at how easy this withdrawal had been.

Case 2. This 22-year-old white man, a Navy veteran, had had two heroin withdrawals while he was an inpatient at a Veterans Administration hospital. He had also had one 30-day outpatient withdrawal on methadone. The onset of significant withdrawal symptoms, he claimed, would lead him back to heroin use. He had been on methadone maintenance for six months, with an average dose of approximately 100 mg. per day, when he was incarcerated for an old offense.

While in jail, he was withdrawn from methadone over a 30-day period. Subsequent visits to my office revealed that he was astonished by how minimal his withdrawal symptoms had been while he was in jail. He appeared physically healthy.

Case 3. This 20-year-old white man had been addicted to heroin for approximately two years. He had previously had two 30-day outpatient withdrawals on methadone. He eventually started on the methadone maintenance program, cutting his own dosage from 100 mg. to an average of 60 mg. per day.

After his enforced 30-day withdrawal while in jail, follow-up visits to my office showed that he had had minimal subjective discomfort. Physically, he looked and felt better.

All three young men had repeated difficulty withdrawing from methadone. Whether the withdrawal had occurred on an inpatient or outpatient basis, they had complained of excruciating pain, insomnia, anorexia, and other symptoms, even when the withdrawal was gradual. Surprisingly, sudden withdrawal in jail produced milder, gradually subsiding symptoms.

One wonders if the medical profession has ignored the classic 1948 work of Isbell and associates (2) and the more recent article by Lipkowitz and associates (1) concerning withdrawal from methadone. Do we tend to overprotect and overtreat methadone withdrawal patients?

REFERENCES

1. Lipkowitz MH, Schwartz DW, Lazarus RJ: Abrupt withdrawal of maintenance methadone. JAMA 217:1860–1861, 1971
2. Isbell H, Wikler A, Eisenman AJ, et al: Liability of addiction to 6-demethylamino-4-4-diphenyl-3-heptanone (methadone, "amidone," or "10820") in man. Arch Intern Med 82:362–392, 1948

HARVEY ASHER, M.D.
Nashville, Tenn.

Chlorpromazine Contraindicated in Delirium Tremens

SIR: Understandably, a concise guide to the "Emergency Room Treatment of the Drug-Abusing Patient" by Dr. J.L. Chapel (March 1973 issue) is not the place to expound on conflicting therapeutic viewpoints. I feel, however, that the use of "100 mg. of chlorpromazine . . . intramuscularly every two to four hours" in the management of alcoholic delirium tremens (DTs) is contraindicated despite its current popularity.

There is some evidence that mortality is increased when this drug is used. Also, patients presenting with DTs have neuropsychiatric abnormalities that are often difficult to distinguish from or coexist with hepatic encephalopathy. Read and associates (1) demonstrated that patients with cirrhosis and hepatic encephalopathy are extremely sensitive to chlorpromazine, which depresses cerebral function or leads to clinical deterioration by hindering removal of blood ammonia.

As there is a predisposition to the development of jaundice in chronic alcoholics and others with hypoproteinemic states, one would not wish to further compromise hepatic functioning by administering chlorpromazine, which, even in 25 percent of healthy patients, leads to anicteric cholestatic jaundice.

Other undesirable effects that might complicate the medical management of already seriously ill and dehydrated patients (many with concomitant congestive heart failure, bronchitis, or emphysema) include tachycardia, quinidine-like electrocardiographic changes, hypotension, slight diuresis (by depressing the pituitary antidiuretic hormone and inhibiting renal tubular reabsorption), and lowering of the convulsive threshold (2).

As a much safer drug of first choice I would suggest diazepam (Valium), administered intramuscularly in doses of 10 mg. every hour or two until the patient is settled. The daily dosage should be from 30 to 50 mg. In addition to its tranquilizing properties, diazepam is an anticonvulsant and eliminates the need for diphenylhydantoin sodium (Dilantin). Paraldehyde, also safe, is rather unsuitable for injection and taken orally is a gastric irritant, especially to alcoholics, many of whom already have gastritis.

REFERENCES

1. Read AE, Laidlaw J, McCarthy CF: Effects of chlorpromazine in patients with hepatic disease. Br Med J 3:497–499, 1969
2. Ban TA: Psychopharmacology. Baltimore, Williams & Wilkins Co, 1969, p 216

R. KALDA, M.D.
Toronto, Ont., Canada

SIR: Dr. Chapel's article contained, in my opinion, a rather serious error in recommending chlorpromazine as an alternate to paraldehyde in the treatment of delirium tremens.

The most impressive study in my 1970 review of the literature (1) was one by Golbert and associates (2) that compared four groups of patients treated for alcohol withdrawal. One group was treated with paraldehyde and chloral hydrate, one with alcohol, one with chlorpromazine, and one with chlordiazepoxide. The conclusion reached was that chlorpromazine, a phenothiazine, was comparatively ineffective and associated with serious complications.

Isbell and associates concluded in their classical paper (3) that the principal treatment of any drug withdrawal state was the substitution and then slow withdrawal of a pharmacologically similar drug. Alcohol belongs to the hypnotic sedative group of drugs and is pharmacologically quite dissimilar to chlorpromazine.

I am satisfied from my reading and can cite chapter and verse from the literature that if Dr. Chapel's advice to use chlorpromazine is followed there will be an increase in incidences of pneumonias, convulsions, and even deaths in the patients so treated. Although paraldehyde is regarded as sound therapy by some, many people experienced in the field feel that chlordiazepoxide, because of its high level of safety and, in contrast to paraldehyde, its absence of liver toxicity, is the drug of choice.

I might question the editorial policy that publishes such an article as Dr. Chapel's. It really has no new developments in it, nor anything that would not be properly described in any good textbook of psychiatry. It makes me wonder whether Dr. Chapel's position in academia, where one must publish or perish, had something to do with the paper.

REFERENCES

1. Treatment of alcohol withdrawal syndromes. The Medical Letter, March 5, 1971, pp 19–20
2. Golbert TM, Sanz CJ, Rose HD, et al: Comparative evaluation of treatments of alcohol withdrawal syndromes. JAMA 201:113–116, 1967
3. Isbell H, Fraser HF, Wikler A, et al: An experimental study of the etiology of "rum fits" and delirium tremens. Q J Stud Alcohol 16:1–33, 1955

GEORGE A. ROGERS, M.D.
Camden, N.J.

Dr. Chapel Replies

SIR: My thanks to Drs. Kalda and Rogers for pointing out my error in advocating chlorpromazine in the treatment of alcoholic delirium tremens. I can offer no valid excuse for this mistake and can only say I really should have known better.

There is no doubt that studies show chlordiazepoxide to be superior in the management of DTs and the paragraph in question should read: "For treatment the patient must be hospitalized. Fluid balance is critical; most patients will require several liters a day. On admission, 100 mg. of chlordiazepoxide hydrochloride (Librium) should be given intramuscularly, then 25 to 50 mg. orally every four hours thereafter, with total daily dosage not to exceed 200 mg. Diphenylhydantoin sodium (Dilantin), in doses of 100 mg. every four hours, may be added to prevent convulsions."

Steps are being taken to correct this error on the reprints.

It might be pointed out, however, that not "all good textbooks of psychiatry" advocate chlordiazepoxide over chlorpromazine. For example, Solomon (1, p. 482), Chafetz (2, p. 1017), and Freedman (3) still advocate chlorpromazine (Thorazine).

REFERENCES

1. Solomon S: Other neurological syndromes, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, pp 473–486
2. Chafetz ME: Addictions, III: alcoholism. Ibid, pp 1011–1026
3. Freedman AM: Modern Synopsis of Comprehensive Textbook of Psychiatry. Baltimore, Williams & Wilkins Co, 1972, p 396

JAMES L. CHAPEL, M.D.
Columbia, Mo.

Is Tardive Dyskinesia a Drug Effect?

SIR: In his article "Tardive Dyskinesia: Side Effect or Not?" (April 1973 issue), Dr. John P. Curran raises the question of whether tardive dyskinesia is a side effect of the neuroleptic drugs or not. In a previous article (1), Ettinger and he raised the same question and suggested that an undiagnosed hepatic disorder may be responsible for motor abnormalities in drug-treated patients. However, liver dysfunctions were not detected in the three cases reported in the article under discussion.

Dr. Curran also states that there must be a temporal relationship between drug administration and dyskinesia in order to prove that this effect is really caused by a neuroleptic agent. In all three of his cases there was a clear-cut relationship between dyskinetic symptoms and treatment with neuroleptics.

He questions the validity of the conclusions of one of my publications (2), but he also mentions the findings that do support the same conclusions in a subsequent paper (3). He asks why drugs should be discontinued in the presence of dyskinesia when the administration of such compounds tends to reduce this condition. In a recent article published in this journal (4), I emphasized the danger of administering neuroleptics to patients with tardive dyskinesia because of the risk of further damaging the central nervous system.

Dr. Curran also questions the existence of tardive dyskinesia as a drug-induced clinical entity since the symptom may manifest itself after the withdrawal of medication and since it may subside after the reinstitution of treatment. This paradoxical phenomenon has been the object of considerable study on the part of investigators. A recent paper (5) dealt with this problem and offered an explanation based on known biochemical mechanisms.

After all this, I must raise the question: What has Dr. Curran contributed to prove that tardive dyskinesia may not be a drug effect?

REFERENCES

1. Ettinger M, Curran J: Liver disease and phenothiazines. Minn Med 53:731–736, 1970
2. Crane GE: High doses of trifluoperazine and tardive dyskinesia. Arch Neurol 22:176–180, 1970
3. Crane GE, Naranjo ER: Motor disorders induced by neuroleptics. Arch Gen Psychiatry 24:179–184, 1971
4. Crane GE: Prevention and management of tardive dyskinesia. Am J Psychiatry 129:466–467, 1972
5. Klawans HL Jr: The pharmacology of tardive dyskinesias. Am J Psychiatry 130:82–86, 1973

GEORGE E. CRANE, M.D.
Baltimore, Md.

Dr. Curran Replies

SIR: There are several issues regarding tardive dyskinesia: 1) What is it? 2) What is the relationship between it and neuroleptics? 3) How do we prevent it? and 4) How do we manage it? Dr. Crane addresses himself to the second and fourth of these questions.

Regarding the question of the relationship between tardive dyskinesia and neuroleptics, my article was written not to deny that there is a relationship between the two (my case reports clearly provide evidence that there is) but to question the wisdom of describing it as a *side effect* relationship. As physicians our instinctive reaction to a "side effect" is to immediately withdraw the offending agent. As I note in my article, and as I can testify from personal experience with other cases, this can be a serious error when we are dealing with tardive dyskinesia.

Dr. Crane asks what I have contributed toward proving that tardive dyskinesia may not be a drug effect. I hope that I have contributed to understanding it precisely as a drug effect, but not as a side effect. To some readers this may be an insignificant difference in emphasis, a mere quibble. Yet a close reading of Crane's December 1971 letter to this journal (1) compared with his October 1972 article (2) suggests, in my opinion, that he himself has come to appreciate this difference.

This brings us to the problem of managing tardive dyskinesia. In the same article (2) in which Dr. Crane discussed the danger of administering neuroleptics to tardive dyskinesia patients, he also made some qualifying statements that I would

like to quote at length because I find myself in substantial agreement with them:

> In some cases of severe mental disorder, however, the prescription of a relatively large amount of medication is required, even in the presence of pronounced neurologic impairment. The danger of aggravating the situation may be very real, but a clear understanding of the total clinical picture will put the clinician in a position to weigh on an individual basis the advantages as opposed to the disadvantages of drug therapy.

In general one has to consider four factors in managing tardive dyskinesia: mode of onset, severity, social disability, and presence of psychosis. If the onset of the syndrome is clearly in response to withdrawal of neuroleptics, as in my series, then the clinician should probably consider restarting the neuroleptic. If, however, the syndrome appears during treatment, then administration of thiopropazate may be indicated (3). Problems of severity and social disability were discussed by Dr. Crane in his article (2); I agree with his consideration of these matters. The presence of psychosis, especially an acute psychotic reaction, may render treatment with a neuroleptic imperative, overruling all other considerations (for example, see case 2 of my series in the April 1973 article).

While it is true that any psychosis can remit spontaneously, I honestly do not see how one can withhold a treatment of proved efficacy for fear of inflicting or aggravating putative brain damage. Of course, one should establish the minimal effective dosage as rapidly as possible, avoid the routine use of anticholinergics, as Klawans (4) suggested, and attempt to *slowly* withdraw the neuroleptic after the patient has been stabilized in a nonpsychotic state for, say, six months.

Dr. Crane deserves considerable credit for his tenacious, energetic pursuit of this puzzling clinical problem. But he has not, in my judgment, yet demonstrated that tardive dyskinesia is a neuroleptic side effect.

REFERENCES

1. Crane GE: Package inserts and tardive dyskinesia (Ltr to Ed). Am J Psychiatry 128:783, 1971
2. Crane GE: Prevention and management of tardive dyskinesia. Am J Psychiatry 129:466–467, 1972
3. Curran JP: Management of tardive dyskinesia with thiopropazate. Am J Psychiatry 130:925–927, 1973
4. Klawans HL Jr: The pharmacology of tardive dyskinesias. Am J Psychiatry 130:82–86, 1973

JOHN P. CURRAN, M.D.
Minneapolis, Minn.

Freud and the Americans

SIR: It is not possible for me to reconcile the scene described at Putnam's camp in Roy R. Grinker, Sr.'s review of Nathan G. Hale, Jr.'s book *Freud and the Americans* (April 1973 issue) with the warm friendship, cooperation, and understanding conveyed in the letters between Putnam and Freud from 1909 to 1916 after this meeting as described in a book edited by Hale (1).

Would it be possible for Dr. Grinker to comment on this?

REFERENCE

1. Hale NG Jr (ed): James Jackson Putnam and Psychoanalysis. Cambridge, Mass, Harvard University Press, 1971

PHYLLIS RUBINTON
New York, N.Y.

Dr. Grinker Replies

SIR: There is no question about Freud's antipathy toward Americans. It is commonly known that Jung wrote Freud during his visit here and indicated that if Freud minimized the "sexual" aspects of psychoanalysis the Americans would accept Freudian theories. Freud felt that Americans would eventually distort the field.

Secondly, Freud hated Woodrow Wilson, who could not put his 14 points through Congress after World War I.

Finally, in a personal communication to me while I was his analysand, Freud related that while at Putnam's camp he suffered from an intestinal disorder with cramps. People there saw him writhing on the ground and asked him, "How are you feeling, Professor Freud?" He answered, "Terribly," to which they responded, "That's too bad," and walked away. From this period, long before Jung's communication and Wilson's failure, Freud took a dim view of Americans. Was he correct?

ROY R. GRINKER, SR., M.D.
Chicago, Ill.

Methaqualone as Aphrodisiac

SIR: The timely article "Quaalude Alley: A One-Way Street" by Drs. Bridge and Ellinwood (February 1973 issue) brings to light the misuse of methaqualone (Quaalude, Sopor, Somnafac, Parest).

An important reason for its widespread use among high school and college students is its reputation as a supposed aphrodisiac. This was reported by patients in Philadelphia nearly three years ago. Two years later, patients returning from distant colleges reported that "Ludes" were being promoted by their friends for the same purpose.

This drug is all too frequently supplied on request by physicians, sold by pharmacists with or without prescription, and shared by friends on the street. Patients have described serious loss of motor and intellectual control because of its sedative effect, while at the same time they deny that the drug has any sedative effect.

SELMA KRAMER, M.D.
Philadelphia, Pa.

The Safety of Hypnoses

SIR: The article "An Episode of Acute, Self-Limiting Depersonalization Following a First Session of Hypnosis" by Drs. Wineburg and Straker (January 1973 issue) is very interesting and especially instructive. But I doubt that the authors drew the right conclusions.

Hypnoses, other than those for demonstration purposes, are performed frequently—quite often by laymen who are not very experienced. Years ago I had a patient who told me that as a teenager he had hypnotized most of his schoolmates without any apparent deleterious aftereffects whatsoever. Psychiatrists, psychologists, dentists, and others hypnotize many patients ev-

ery day. Psychiatrists and psychologists also perform daily hypnoanalyses. It is impossible to calculate the number of hypnoses and hypnoanalyses done every 24 hours that have no dire results. To the contrary, in 95 percent of the cases the effects are beneficial to the person undergoing hypnosis.

The last time an unfortunate aftereffect was reported from the Mt. Sinai Hospital in New York City was in the year 1949. E.D. Joseph and associates (1) reported that a patient had to undergo several other procedures after the hypnosis. It could not be proved that the psychosis which followed hypnosis in this very sick patient had any relation to the hypnosis itself.

I suppose I have performed about 10,000 hypnoses and hypnoanalyses in my practice, most probably many more. There was only one case in which an unforeseen and undesirable aftereffect resulted. In this case again it was not possible to definitely ascribe the regression of the patient to the hypnoses because she had not been hypnotized for a whole week before her regression.

Case 1. Although I had strongly advised that this patient should not be visited by her parents because of an unresolved oedipus complex, they did visit her. The father caressed the patient's arm in the same way he had when the patient was a child; there was a recurrence of her incestuous shame and guilt feelings. When the parents left, the patient immediately vomited and then regressed to the age of four, when she had had an accident and her mother had stayed with her constantly.

The patient demanded a pair of scissors at this time, but I was afraid to give them to her because she was suicidal. After a few days, however, I gave her a pair of old blunt scissors. She broke them apart and immediately became her actual age and in total contact with reality. The scissors had been her symbol for the "communion" between herself and her father. Had I given them to her when she had first demanded them the state of regression would most likely have terminated then and there. The patient had learned the technique of regression for therapeutic purposes through the hypnoanalytic sessions, but the regression itself was a consequence of her father's behavior.

This has been the only case in which a deleterious aftereffect occurred out of thousands of hypnoses and hypoanalyses (even here, however, the regression occurred only after hypnoses and not necessarily as their effect), and hypnoses are being performed daily by relatively untrained people without adverse consequences. Thus the statement of Drs. Wineburg and Straker that "hypnosis is a serious medical procedure and requires adequate safeguards" does not seem warranted.

I certainly deplore the use of hypnosis as a parlor sport, but there is no law against it.

REFERENCE

1. Joseph ED, Peck SM, Kaufman MR: A psychological study of neurodermatitis with a case report. Journal of Mt. Sinai Hospital (New York City) 15:360–366, 1949

EDITH KLEMPERER, M.D.
New York, N.Y.

Drs. Wineburg and Straker Reply

SIR: It is a pleasure to comment on Dr. Klemperer's critique of our report of a mishap following an uneventful episode of hypnosis.

We agree with Dr. Klemperer that most hypnotic trances are induced by untrained laymen and naïve nonpsychiatrists. We furthermore concur that morbidity is low and mortality is virtually nonexistent.

However, the aphorism ascribed to Pierre Janet expresses our concern: "The only danger of hypnosis is that it is not dangerous enough." The ease with which the trance is induced, combined with the lack of follow-up, has yielded the false assumption that hypnosis may be applied indiscriminately with never a possibility of harm.

Objective studies have shown significant frequency of sequelae to hypnosis. Josephine Hilgard (1) reported that "of 120 university students . . . 15 percent had some kind of reaction to hypnosis that endured for an hour or longer. . . ."

Dr. Klemperer's record of 10,000 cases with only one incident of morbidity is more a tribute to her skill in selection, preparation, and follow-up than a testimonial to the *absolute* safety of hypnosis.

REFERENCE

1. Hilgard J: Personal communication, Oct 1972

ELLIOT N. WINEBURG, M.D.
NORMAN STRAKER, M.D.
New York, N.Y.

Therapeutic Spiritual Experiences

SIR: It was refreshing to see Dr. Horton's article "The Mystical Experience as a Suicide Preventive" (March 1973 issue). More psychiatrists need to recognize the existence of man's spiritual nature and become able to use these experiences therapeutically. There are resources that we completely ignore if these experiences are automatically termed psychotic. I know of cases where a meaningful experience that could have given a patient great strength was negated by a skeptical psychiatrist.

The sense of complete forgiveness and acceptance by a loving Lord and by a group of like-minded people is the antithesis of a depressive state where the patient feels worthless and unloved. It is the "I'm ok" position of Dr. Harris (1, especially p. 237), because God makes a person ok.

Kildahl (2) documented the fact that there was a significant difference on the depression scale of the Minnesota Multiphasic Personality Inventory (MMPI) between a group of people who practiced glossolalia ("speaking in tongues") and a group matched in other respects who did not. (Glossolalia is a possible manifestation of the experience known as the baptism of the Holy Spirit; the practice is becoming quite common at this time, even in main-line churches.) In this study the glossolaliasts still maintained their feeling of well-being when tested a year later. Their assurance that God loved them had changed their lives. The study also showed that one group was not any more mentally healthy than the other: "Both groups contained persons along the continuum from the mentally ill to the remarkably mature."

I wonder upon what criteria the three patients whose cases were described in Dr. Horton's paper were diagnosed schizophrenic. In some institutions it is necessary only to mention religious ideas in order to have this label applied. Of course, it is extremely difficult to draw the line between what is culturally normal in some religious groups and what is frankly delusional. Perhaps some of us should have the honesty to admit we do not know how to distinguish this difference with certainty rather than dismiss everything nonmaterial as psychotic. Each religious belief should be evaluated in the context of an individual's

total personality, and the criterion for judgment should be the results of such experiences and whether they produce positive actions in the life. "You will recognize them by their fruits" (3).

In the area of drug abuse, for example, spiritual experiences have been found much more therapeutic in many cases than anything orthodox psychiatry has so far offered. Many drug addicts have been rescued by the organization founded by David Wilkerson (4), Teen Challenge. When members of this organization appear for court-ordered psychiatric examinations, however, they are very careful not to mention the religious reasons for their cure or they run the risk of being considered psychotic. The mere thought of a God who is accessible and influences people terrifies some psychiatrists into prescribing phenothiazines.

Psychiatrists should be aware of the resource of Teen Challenge, which has group homes and offices in many large towns. As Alcoholics Anonymous has helped many an alcoholic when orthodox psychiatry could not, so Teen Challenge helps young drug addicts.

Of course, there are those who think God tells them to blow up the White House, etc.; these individuals will be found to be disorganized in all parts of their life. There are others who believe God inspires them to positive action and in this strength they are able to overcome some of their problems. Whether the therapist himself accepts this or not, if he dismisses these beliefs as part of the patient's illness he is neglecting a valuable therapeutic tool and ignoring a large segment of society that uses these beliefs as the foundation for a productive life.

REFERENCES

1. Harris TA: I'm OK—You're OK: A Practical Guide to Transactional Analysis. New York, Harper & Row, 1969
2. Kildahl JP: The Psychology of Speaking in Tongues. New York, Harper & Row, 1972
3. Matthew 7:20, New English Bible. New York, Oxford University Press, 1970
4. Wilkerson D: The Cross and the Switchblade. New York, Spire Books, 1963

HAZEL FARKAS, M.B., CH.B.
Baltimore, Md.

LETTERS TO THE EDITOR are welcomed and will be published, if found suitable, as space permits. Like other material submitted for publication, they must be typewritten double-spaced. The letters should not exceed 500 words, including references, unless a special arrangement has been made with the Editor, and they will be subject to the usual editing.

BOOK REVIEWS

Clinical Studies in Psychiatry, *by Harry Stack Sullivan, M.D., edited by Helen Swick Perry, Mary Ladd Gawel, and Martha Gibbon. New York, W.W. Norton & Co., 1973, 378 pp., $3.65 (paper).*

Rarely—rarely indeed—does a review assignment turn into an exciting and stimulating pleasure. This one does.

Carefully rereading Sullivan, here at his clinical best, was for me a rewarding, heartening, and at times even an awesome experience. Let me explain. The papers comprising this volume are the famous Chestnut Lodge lectures, delivered about 30 years ago to a brilliant gathering of psychotherapists and scientists that included, besides Dexter M. Bullard as host, Mabel Cohen, Edna Dyar, Frieda Fromm-Reichmann, Douglas Noble, Robert Morse, David Rioch, Alfred Stanton, Edith Weigert, Ben Weininger, and Mabel Wilkin. Certainly this stimulating, responsive—and at times, I'm sure, cantankerous—audience brought out the best in Sullivan. And this best is so good, so penetrating, and profound that even in the rereading it awakens a sense of awe and gratitude that one is still privy at this distance to such an observing mind.

Sullivan's commentaries on obsessionalism and hysteria seem to have worn best over the years. This may seem like an odd observation in that most of Sullivan's reputation seems to have come from his meticulous study of the schizophrenic syndrome. Perhaps because of my personal bias or perhaps because so much understanding of schizophrenic processes has followed his pioneering, the sections covering this material seem slightly precious today. Most present-day workers don't assess their schizophrenic patients as being quite so fragile as Sullivan did. His notes on paranoid developments, however, continue to be unmatched anywhere.

Also, it should constantly be kept in mind that these are clinical studies *within a psychotherapeutic framework* and that they are strongly reflective, at the same time, of interpersonal factors in the doctor-patient relationship. With this in mind, it is especially fascinating to compare Sullivan's observations with those of Frieda Fromm-Reichmann (1), his contemporary. Such a comparison brings into sharp focus the fact that Sullivan, the man, was challenged by and was exquisitely sensitive and alert to the aggressive factors in his patients, as compared to Fromm-Reichmann's feminine patience and calm as she waited for aggressive displays to run their course so that something more tender, and to her, more interesting, could take place in the relationship.

The publisher is to be congratulated on this easy-reading, pleasantly sized, and well-constructed paperback edition of its original 1956 hardback volume. This program of making Sullivan easily available to student and professional alike is no doubt making a very real contribution to the steadily growing enthusiasm for Sullivan's writings. Additional very real contributions are coming from Ralph Crowley of New York (2), who describes how Sullivan is coming to "almost secretly dominate American psychiatry," and from David Elkind (3), who notes that "the work of Harry Stack Sullivan, generally regarded as America's most original psychiatrist, is only now beginning to win widespread recognition."

The long, arduous efforts of the William Alanson White Psychiatric Foundation's committee on publication of Sullivan's writings—comprised of the late Mabel Blake Cohen, M.D., Dexter M. Bullard, M.D., David McK. Rioch, M.D., Otto Allen Will, M.D., and Helen Swick Perry, editorial consultant—are now paying off handsomely. These people deserve our continuing gratitude.

The uninitiated reader should be warned that Sullivan cannot be approached casually. His special language and system must be digested, and this requires serious scholastic endeavor. Be encouraged, however. It is worth the effort. An understanding of "security operations" alone, for example, can bring an important benefit to a whole psychiatric career.

REFERENCES

1. Fromm-Reichmann F: Psychoanalysis and Psychotherapy. Edited by Bullard DM. Chicago, University of Chicago Press, 1959
2. Crowley RM: On Sullivan: I. William Alanson White Newsletter 4:1-3, Summer 1970
3. Elkind D: 'Good me' or 'bad me'—the Sullivan approach to personality. New York Times Magazine, September 24, 1972

KENNETH L. ARTISS, M.D.
Rockville, Md.

Beyond Freedom and Dignity, *by B.F. Skinner. New York, Alfred A. Knopf, 1972, 225 pp., $6.95.*

If Dr. Skinner had limited his call for a new science of man to a plea for study and research of human behavior by way of an objective, observational, and inductive methodology, few would disagree with his thesis. It is when he discourses in essentially philosophical areas that the romanticism of his thinking becomes apparent and the speculative nature of his utopia becomes controversial.

Between the proponents of determinism and free will there is no middle ground. The latter hold that man possesses the capability to deliberate, decide, and act independent of prior experience and is to be praised or blamed for his behavior. Dr. Skinner, the most prominent current behaviorist, rejects this view of autonomous man, holding that man is the consequence of the influence of the environment on the corporeal entity with its genetic endowment and potential for adaptation. Credit or blame for behavior should be placed on the environment.

The environment not only prods or lashes (i.e., stimulates) the individual, it also *selects.* Behavior is shaped and maintained by its consequences when these reinforce that behavior. Only by recognizing what the environment does to an organism, not only before but also after it responds, can the interaction between the organism and environment be understood in a more comprehensive way. Almost all living things act to free themselves from harmful contacts. Man does this through such processes as simple reflexes, conditioned reflexes, and respondent and operant conditioning.

Man's struggle for freedom is thus not due to a will to be free but to certain behavioral processes, "characteristic of the human organism," to escape from or to avoid "aversive" features

of the environment. Similarly, a man's dignity or worth is the measure of the credit given him for his behavior and is inversely related to the visibility of the causes of that behavior. Thus while "freedom" is an issue raised by aversive consequences of behavior, dignity concerns positive reinforcement.

Simply stated, dignity and freedom are concepts developed as a consequence of the exposure of the individual, experientially and in his evolutionary context, to his environment. They are part of the value system of a culture and are contingencies of reinforcement under which people live, comparable to those contingencies conceptualized as health, wealth, wisdom, order, and security.

Parenthetically, the irony might be noted that primitive man appears to have felt himself to be totally at the mercy of his environment, and, in the strictest sense of his position, Dr. Skinner returns to that concept—without the animistic beliefs. The ultimate value in his system is survival of the species.

Dr. Skinner dismisses psychoanalytic concepts as modern-day versions of the animism of primitive societies or the beliefs of possession by evil spirits. The division of the personality into id, ego, and superego and the personification of these three as being responsible by their interactions for the behavior of the man in whom they reside is comparable to animism from a scientific viewpoint. Skinner holds that the physical sciences made no progress until they gave up personifying things in this way and that the behavioral sciences, which are at least 100 years behind the physical sciences in this respect, will make no progress until they do likewise.

Feelings, both internally and externally stimulated, are to be viewed as by-products of the contingencies of survival. Behavior may be accompanied by good or bad feelings according to the consequences of the behavior, and feelings are generated in members of a social group by the reinforcers or values that persons in that group have come to use to effect behavior change or conformity. Thus an event that may occasion pain or anxious or aggressive feelings may condition an individual, or reinforce a tendency in him, to subsequently act in a particular way, but it is not the pain, anxiety, or aggression that causes him to do so.

While in some ways this represents a return to the postulates of psychologists in the early part of this century, it is in these not too subtle but vastly important distinctions that the essence of Dr. Skinner's disagreement with modern psychology and psychiatry lies. The conceptualization of feeling states such as anxiety, aggression, etc., as the causes of behavior is irrelevant and self-defeating in the pursuit of understanding behavior in a scientific way. In his terms, the feelings that accompany behavior have preoccupied behavioral scientists as the dominant factors to be understood and have displaced study of the really important factors pertinent to the science and technology of behavior.

It is when Dr. Skinner applies his theories to the management of a culture that he becomes less categorical in his statements, with frequent use of the subjunctive tense. In the chapters on the evolution and design of a culture, he becomes less certain about the practicality of totally reforming society. According to his definition, a utopia is a total environment in which all parts work together without conflict between the parts. But the single most important feature of a utopian design is that survival of the community can be made important to all its members.

Recognizing the problems of implementation, Dr. Skinner suggests that perhaps the development of better practices should be undertaken in piecemeal fashion. For example, solving the problem of deserters and draft dodgers (who, incidentally, constitute only a small portion of their cohort) requires changing the contingencies that induce young people to behave in given ways toward their government. But he does not specify any particular means. Nor does he mention that changing the contingencies for one set of individuals might result in the emergence of comparable or other problems among some or all of the larger group who, under present contingencies, present no such problem. Similarly, to solve the problem of war, the answer is to be found in changing the circumstances under which men and nations make war.

Despite statements of the difficulties at hand, Dr. Skinner returns to the theoretical possibility of intentionally designing a presumably better, if not utopian, culture. He recognizes that such a society would not necessarily be liked by those persons who were "re-formed" but would be liked by their successors who live in it. Yet the latter group would necessarily also be the product of an older culture. Moreover, he recognizes that the designer, and presumably the master, would himself be culture-bound. Given the author's premise that man is the product of his biological evolution modified by his environment and that he has no independent power in a scientific sense to modify it, I have the impression that either he realizes this and his advocacy of a great design for a perfect world is presented somewhat with tongue in cheek or else he is still struggling with his scientific concepts.

Dr. Skinner prepares for attack by his critics by reminding the reader of the great scientific innovators who were rejected in their own day. In either case, Dr. Skinner displays his considerable skill in writing a romantic script under the guise of science—a form of science fiction. Twenty-five years ago he wrote a comparable fantasy in *Walden Two* (1), whose remarkable appeal over the years appears to be due to the emotions or feelings aroused in its readers. This book is a natural how-to sequel.

The author is on more solid ground in the early portion of this latest work. There is considerable appeal for a new science of behavior based on objective observations of the interaction of man and his environment, on which there would be based a new technology of behavior. In the later portion his formula for a comprehensive, systematic approach to attain behavior modification in, and control of, others raises many interesting questions. For example, whom but Dr. Skinner would Dr. Skinner accept as this absolute controller of the culture? And anyway, hasn't someone already written about how it will be in 1984?

REFERENCE

1. Skinner BF: Walden Two. New York, Macmillan Co, 1948

JOHN DONNELLY, M.D.
Hartford, Conn.

Why People Kill Themselves: A Summary of Research Findings on Suicidal Behavior, *by David Lester, Ph.D. Springfield, Ill., Charles C Thomas, 1972, 353 pp., $14.75.*

In reviewing this book I will try to perform a service to the reader by clarifying what it *is* as opposed to what it seems to be. The primary title suggests that the book provides answers to the important question "Why do people kill themselves?" In fact, there are none. The subtitle is what the book is really about. And as the author himself concludes, after an exhaustive but by no means complete review of the literature, the research is of generally poor quality, and the results are inconclusive. In fact, in the author's opinion, suicide research is so outstandingly poor that the causes of this phenomenon should in themselves be explored.

The flyleaf states that "all available research is reviewed. . . ." This is not true. In the preface the author cites several limitations of the book, among which is that it is restricted to

writings in the English language. The most important limitation, however, is that the author has relied upon the bibliography provided by Farberow and Shneidman for the literature up to 1957. The flyleaf also states that the author "provides a critical and unbiased view of research that has been conducted into suicidal behavior." In my opinion, the author does reveal a bias, and he seems to accept, uncritically, the bias of Farberow and Shneidman, whose incomplete bibliography is the one he uses.

The author's bias, for the benefit of the reader, is that research (good, valid, acceptable) is defined as a project that has a hypothesis. This hypothesis must then be tested by an experimental design that includes a control group and an experimental group. The hypothesis is then either advanced, rejected, or judged irrelevant to the data and analysis. The unseen and unspoken bias is that a single case study is not research. This is an unfortunate and damaging bias, because it eliminates some of the most valuable sources of data relevant to the question "Why do people kill themselves?"

It is to the author's credit that he stumbles upon this realization himself, in his last answer to his last question in the book, "Where do we go?" He answers that the two areas which are most promising for suicide research are the childhood experiences of the suicidal individual and his social relationships. But the richest source of data in these areas is the psychoanalytic literature, in which case studies do not qualify, somehow, as research. If, after reviewing one bias of what constitutes acceptable suicide research, the author succeeds in looking in the direction of detailed case studies and long, painstaking analytic observation, he will have performed a valuable service to himself and to his potential readers. It is, after all, a sobering experience to review and summarize a large part of the world research on suicide and find it a hodgepodge of crude work!

To illustrate, the references include two articles by Norman Tabachnick: "Interpersonal Relations in Suicide Attempts" and "Comparative Study of Accidental and Suicidal Death." Yet there is no reference to his article on "Countertransference Crisis in Suicidal Attempts" (1). This last paper is a penetrating examination in depth and detail of an interpersonal relationship that led to a suicide attempt. There are other important omissions that the author is either unaware of or does not explain.

My own bias is the psychodynamic-psychoanalytic orientation. I would have preferred that the author omit the research on the correlation of suicide with phases of the moon, for example.

The references are listed alphabetically at the end of the book, by author. There is no topic reference or index and therefore no way the reader can easily find a particular summary he is looking for.

In summary, the book reflects much that is unfortunate in the area of suicide research. However, it does represent a quick way to review a large part of what is considered suicide research by some researchers in the field. Fortunately, the author recognizes the inadequacy of this type of research on suicide and begins to look in more promising directions: the in-depth study of the early childhood and personality development of the individual. The barrier here is the unwillingness of most of us to explore the roots of our own self-destructiveness. It is just too anxiety-provoking!

REFERENCE

1. Tabachnick N: Countertransference crisis in suicidal attempts. Arch Gen Psychiatry 4:572–578, 1961

VICTOR BLOOM, M.D.
Detroit, Mich.

Biological Basis of Alcoholism, *edited by Yedy Israel, Ph.D., and Jorge Mardones, M.D. New York, John Wiley & Sons, 1971, 442 pp., $19.95.*

In this volume a selected group of 29 researchers, all recognized experts in their respective fields, analyze the different approaches and recent findings of their work in an effort to establish a scientific basis for the understanding of alcoholism. These investigations begin at the subcellular and cellular levels and increase in complexity and level of integration to the organ, the individual, and the society. The result is a detailed and exhaustive review of the biological basis of alcoholism, documented by extensive references.

While stressing the physical aspects of alcoholism, the contributors recognize that psyche and soma cannot be separated and that there is an interaction of alcohol with the biological system, the genetic characteristics of the system, as well as with psychological and cultural factors.

Some of the specific topics treated are the different enzymatic processes that metabolize and control the rate of alcohol elimination, the effects of alcohol on the nerve cell, the mechanisms of adaptation to the continuous presence of the drug, and the effect of substances other than ethanol that are present in alcoholic beverages. Also discussed are the relationship between chronic alcohol ingestion and liver, heart, and pancreatic damage, the nutritional deficiencies in the alcoholic, the role of heredity in determining the appetite for alcohol, the question of how the availability of the drug affects the rate of alcoholism in a population, and the psychological and pharmacological basis for the treatment of alcohol dependence.

Perhaps the most interesting thing about this book is the internationality of the contributors, who came from Denmark, Chile, Canada, the United States, and Finland. The fact that they do not arrive at any hard conclusions testifies to the scientific integrity of this research as well as the complexity of the problem of alcoholism. This book should be in the library of anyone doing research in or studying, in depth, the nature of alcoholism.

FREDERICK LEMERE, M.D.
Seattle, Wash.

The Problematic Self in Kierkegaard and Freud, *by J. Preston Cole. New Haven, Conn., Yale University Press, 1971, 229 pp., $7.50.*

J. Preston Cole's book is a profoundly erudite work. It treats an issue—the *problematic* self—that is of immense and urgent importance to contemporary man. Regretfully, it is strictly confined to the Christian perspective and proffers the ultimate resolution of man's existential despair in the religion of the Son. "Christ," Cole affirms, "is the paradigm of selfhood, the dialectic incarnation of God. In Him is fully manifest the dialectic of the finite and infinite, the temporal and the eternal, necessity and possibility. In short, he is the paradigm of the relationship between man and God" (p. 228).

And so He is! But hath not God other Sons besides? Many, even as I am persuaded, believe as much. But clearly Cole is not to be counted among them.

In *The Self in Transformation* (1) Herbert Fingarette pursued a thesis akin to that of Cole's, admittedly on a simpler plane, and he found great spiritual nurture in the Sons of the East: Confucius, Lao-tse, Zen, etc.

Cole composed his work in the hope that "in this way new light has been thrown both on Freud and Kierkegaard, or that

at least Kierkegaard will have been made intelligible to Freudians, and Freud to Kierkegaardians, who seem eternally at war."

Should the Freudians, and other psychiatrists, too, read this book, as I would heartily recommend, they will most certainly learn a good deal about Kierkegaard's thoughts and teachings, for Cole is a master expositor and superbly skilled in the dialectics of metaphysical arguments. But as for reconciling Freud and Kierkegaard and making peace between these nominal antagonists and their followers, much doubt is warranted.

And yet, are they really at war? Cole tries hard to portray an antagonism that is in fact interpretive rather than real. Freud is "fitted" to the procrustean thesis of Cole's argument. Cole interprets what he quotes from Freud's writings to fit his own presuppositions. Furthermore, while Cole has read much of Freud's writings, he quite evidently has only a literal, not a clinical, understanding of Freud's theories.

But why all this pother about the similarities and divergences between Kierkegaard and Freud? They both dealt with the self, but the one was a positivist psychiatrist, while the other was a metaphysical theologian. Freud had little regard for philosophy and even less for metaphysics. Kierkegaard knew no science.

And yet, paradoxical as it may seem, it can be said that "Kierkegaard carries on from where Freud left off." Freud entertained no illusions. He brilliantly illuminated the self of the here and now. He knew of no transcendence. He mocked the oceanic feeling of the self in transport. Kierkegaard, on the other hand, was ultimately concerned with the "other self," with the second self that transcends the immediate self.

> To the immediate self, which is determined by its own natural desires or drives, there comes the awareness of another mode of being peculiar to man. Dreamingly, Spirit becomes manifest to the individual as a possibility, *his* possibility. Thus his true being, Spirit, is projected as his own reality. An unrealized reality, a reality which is as yet only a possibility (p. 15).

This may appear to some as mystical, but the psychiatrist, and notably the psychoanalyst, should readily perceive the profound validity of this affirmation. They can attest out of their own experience that "in the realm of human existence there is the possibility of 'a second becoming within the first becoming,' as Kierkegaard puts it" (p. 23).

It is not possible in a brief review to do full justice to this work. It is erudite, subtle, gracious, affirmative in spirit, and inspiring. It presents a comprehension of the meaning of man's life that cannot be but antidotal to the prevailing cynicism and despair. The essence of the book is not easily grasped; but it merits careful study and, when understood, will prove immensely rewarding. It speaks in a vernacular alien to the intelligence accustomed to the jargon of positivist science, but it carries instruction that cannot help but enlarge our understanding of existential man, man's singular potentials, and man's unique existence.

REFERENCE

1. Fingarette H: The Self in Transformation. New York, Basic Books, 1963

IAGO GALDSTON, M.D.
Hartford, Conn.

Fundamentals of Electroencephalography, *by Kenneth A. Kooi, M.S., M.D. New York, Harper & Row, 1971, 249 pp., $12.95.*

Dr. Kooi, Professor of Electroencephalography at the University of Michigan Medical School, has written an unusual book reflecting his many years of work in electroencephalography and his indebtedness to Dr. B.K. Bagchi. The book is intended as "a compact source of information about human electrocerebral phenomenology." The orientation is strongly clinical, definitely more American than European in flavor, and with interpretation well rooted in neurophysiology. The presentation of material is functional rather than disease oriented, an approach that yields a format which is quite different from that of any other book on electroencephalography.

One is reminded of Grey Walter's old point about descriptive terms in science. The now obsolete meaning of "astrology" was usurped by pseudoscience, leaving "astronomy" as a less accurate term. And "electroencephalography" would be better termed "electroencephalology." The point is that electroencephalography, as an increasingly routinized clinical tool, had acquired a pejorative connotation, especially among neurologists. This book indicates that electroencephalography is more than just a technique and that the body of knowledge, still rapidly growing, constitutes a field in its own right. The practical and definite clinical value is the theme of this book, but the approach is well suited to a broad and orderly survey of the phenomenon of the electrical activity of the entire brain, both spontaneous and evoked.

The organization, as one would expect, is different. V.A. Basman has contributed eight pages of basic electrical principles. If the reader knew nothing of this, the material, while accurate, would be too concise to be helpful. This material is readily available elsewhere, and it could have been omitted without decreasing the value of the work. In a book with "fundamentals" in the title, a section on instrumentation is imperative; the eight pages devoted to this subject simply are not adequate. The references (all given by chapter) should have included Hill and Parr's *Electroencephalography* (1, 2).

The section on sampling electrical fields is fair and judicious, although the inclusion of actual EEG samples would have given added emphasis. The Michigan electrode array is yet another modified 10–20 system with more electrodes than are generally used in the United States. The serious reader would be well advised to make a plot of electrode placements for working out the sometimes unusual montages employed. The actual illustrations, based on unretouched and remarkably clean tracings, are derived from eight-channel equipment and only rarely show activities from the additional electrodes. Many figures are based on a joined ear-reference technique, which is adequate to the point being illustrated; the text contains a brief but appropriate caveat.

Part 2 of the book, an excellent section, deals with the basis of EEG interpretation. There is a factual review of the genesis and regulation of the normal, spontaneous electrical activity of the brain, followed by its many variations and modifications, which may have some significance. Thus alterations in electroencephalographic voltage, frequency, symmetry, morphology, abundance, and distribution, paroxysmal or steady, are treated in a *general* way without specific regard to definite clinical correlates. This establishes a broad base of normality according to age and level of consciousness, with an enlightened attitude toward minor variations. It is enriched by a new and important dimension which receives subsequent emphasis—that of the changes induced by stimulation as determined by careful study of evoked responses. The relation to mental processes is discussed.

Nearly half of the book (part 3) is devoted to the manifold

ways in which the aforementioned features are modified by and related to the *specific* conditions affecting the central nervous system. These include, of course, the epilepsies, tumor and trauma, circulatory disease, developmental and degenerative disorders, infections, and metabolic and endocrine disturbances. The description, while often rather brief, generally goes beyond the purely phenomenological and indicates concern with the reasons for the abnormalities. Alterations of evoked responses are included as another parameter of evidence to supplement the changes in spontaneous activity. The chapter on psychiatric disorders is brief and pessimistic, while the one on neuroactive drugs is much more complete and very pertinent to psychiatrists.

Dr. Kooi's book is a distinctly personal work. This is reflected in the appreciable data from his own laboratory that bears on the clinical electroencephalographic features in brain tumor and epilepsy, plus the contribution of evoked responses. It is not meant to be a how-to book, nor is it particularly useful as a ready reference, for example, to the electroencephalographic correlates of specific disease states. In review of this, the references to necessary supplementary works are curiously incomplete. I would have added at least a dozen fundamental titles to the brief list of general references, the first of which would have been Kiloh and Osselton's *Clinical Electroencephalography* (3) for general orientation and the second *Electroencephalography and Cerebral Tumours* (4), without which no electroencephalographer can avoid disaster.

In summary, this new type of EEG book does indeed present the fundamentals of EEG. It will be of particular interest to electroencephalographers and technologists who are concerned with training programs. It is quite possible that the book will be a good introductory text to the field of electroencephalography, on which additional basic reading and practical laboratory experience will build a degree of understanding not achieved by more traditional approaches.

REFERENCES

1. Hill JDN, Parr G (eds): Electroencephalography: A Symposium on Its Various Aspects. New York, Macmillan Co, 1950
2. Hill JDN, Parr G (eds): Electroencephalography: A Symposium on Its Various Aspects, 2nd ed. New York, Macmillan Co, 1963
3. Kiloh LG, Osselton JW: Clinical Electroencephalography, 2nd ed. London, Butterworth & Co, 1966
4. Magnus O, Storm van Leeuwen W, Cobb WA (eds): Electroencephalography and Cerebral Tumours. Electroencephalogr Clin Neurophysiol (suppl 19), 1961

CHARLES E. HENRY, PH.D.
Cleveland, Ohio

Children of the Rich, *by Burton N. Wixen, M.D. New York, Crown Publishers, 1973, 209 pp., $5.95.*

This book addresses itself to that relatively small and almost forgotten group—children of the very rich. The author refers to them as CORs, by which he means those youngsters and their families who have such large amounts of money that they are denied little if anything of a material type.

He feels, and probably rightly so, that CORs are often "a wasted resource," and he uses the term "dysgradia" to explain why many of them do not mature emotionally as well as they should.

He cites several case examples from the financial and business world and also from the stage and screen. Dysgradia, as used by Dr. Wixen, refers to an identity problem. These children are often raised by nursemaids, given all the material things they want, and have trust funds ensuring them a sizable income. The middle-class values of hard work, upward striving, etc., are meaningless to many of them. These youngsters can be compared, as others have done, more to lower socioeconomic youngsters than to those from the middle class. While it is true that some CORs succeed, many lead aimless lives.

The author has at least two major suggestions. One is that the therapist should not try to impose his middle-class values on the COR patient. He should set his sights differently and aim for a firmer identity for the patient and even, where possible, his commitment to a reasonable cause. Second, he raises the idea of a CORs Anonymous, which would bring together this rather isolated group of individuals and help them gain strengths and new ideas from the other members.

All in all, this is an interesting, well-written, but not rigidly scientific book. Relatively few of us in the mental health professions have treated such people, but the book gives some valuable suggestions about the problems to be anticipated. It is enjoyable reading even if one does not have such patients and could be helpful if one does. Even such matters as transference, countertransference, and fee schedules are dealt with and are well worth considering.

STUART M. FINCH, M.D.
Ann Arbor, Mich.

Cruel, Poor and Brutal Nations, *by John Cawte, M.D., Ph.D. Honolulu, University Press of Hawaii, 1972, 177 pp., $9.50.*

This psychiatric study of aborigines living on a small island off the northern coast of Australia is an important attempt to deal with a usually neglected problem. What can we do, as psychiatrists and as concerned citizens, to assess and mitigate the culture shock of people who are leapfrogging centuries of technological development in a single generation? How much change can the human organism incorporate? What is the optimal rate of change? Can anything be done to minimize the adverse effects of such change?

The author, Associate Professor of Psychiatry at the University of New South Wales in Sydney, is a Distinguished Fellow of the American Psychiatric Association and a frequent visitor to this country. He also has an advanced degree in anthropology. For ten years he has spent his vacations living with different groups of aborigines in the Australian outback. He has also done field work in Papua, New Guinea. In Australia he is an acknowledged expert on problems of the aborigines and a frequent spokesman for their causes.

The book describes an interdisciplinary study of the aborigines living on Mornington Island in the Gulf of Carpentaria. Psychiatrists, psychologists, anthropologists, a biologist-geneticist, and a geographer combined efforts in what became a brief version of psychiatric field surveys such as Alexander Leighton did in Nigeria and Nova Scotia. A modified Cornell Medical Index was included in the psychological testing.

Especially interesting are the chapters on the Kaiadilt subgroup, which was at the edge of extinction and showed a high rate of serious mental disturbance. Also important is the author's discussion of the cycle of ecological and geographical changes, interpersonal disturbances, and intrapsychic malfunction. There are two chapters on the problems among children that are well worth reading.

The author's writing style is clear and concise. Several pages

of pictures make the setting more real. The book is strongly recommended to those psychiatrists with an interest in ethnopsychiatry, problems of rapid technological change, and majority-minority group relationships. Racism is an important ingredient in the last, and the author has sarcastically chosen for the book's title the description applied to these aborigines by an early explorer. On Mornington Island, as elsewhere, racism has compounded the other problems faced by these people. The book also serves as a useful model for brief, economical psychiatric field research. Finally, by making specific, realistic recommendations for assisting these people, the author illustrates that such field research may have useful consequences for the people under study.

E. FULLER TORREY, M.D.
Rockville, Md.

La faim et le corps: Une étude psychanalytique de l'anorexie mentale, *by Evelyne Kestemberg, Jean Kestemberg, and Simone Decobert. Paris, Presses Universitaires de France, 1972, 301 pp., no price listed (paper).*

Although written from a psychoanalytic approach, this fine book on anorexia nervosa (which is called "mental anorexia" in France and Italy) can be read profitably by nonanalysts as well—for example, by pediatricians, whom the subject interests greatly. The authors, all members of the Paris Psychoanalytical Society, have included a comprehensive review of the psychoanalytic principles and concepts having to do with the development of object relations in the child.

The authors begin with a general chronological review of the literature on anorexia, underlining the main contributions of the more important works. This is followed by a careful, detailed clinical description of three adolescent patients, the initial interviews with them, and their family constellations. The phenomenological acuteness of observation and the richness of language and stylistic quality make this section fascinating reading. The section is completed by a clinical psychoanalysis identifying the constants in the patients' personality organization that became evident in the course of psychotherapy.

The third part of the book consists of metapsychological hypotheses pursued in depth about aspects of hunger and the body in the anoretic personality. These hypotheses offer major contributions to the understanding of the psychoanalytic theory of masochism, the death instinct, and the paradox of a particular autoeroticism described as the orgasm of hunger, in which a basic need such as hunger does not serve as a defense against uncaring self-destruction.

This study is essential for anyone wanting to really understand that paradoxical and mysterious malady, anorexia nervosa.

SAMUEL I. STONE, PH.D.
Boston, Mass.

The Treatment of Alcoholics: An Evaluative Study, *by Sidney Cahn. New York, Oxford University Press, 1970, 239 pp., $7.50.*

This book reviews the services and treatment programs available for the management of alcoholics in the United States, under the auspices of the Cooperative Commission on the Study of Alcoholism. As such, it is a very informative and useful text. However, the title is misleading, and if the reader expects a full evaluation of the various management procedures in the treatment of alcoholics, he will be disappointed.

Although a multicausal approach is emphasized, the author's description of the present status of the causative factors in the production of alcoholism is incomplete and does not include, for instance, reference to the many neurochemical and neurophysiological studies done in the field. The contrast between the different psychopathological models of causation is, however, well done.

Although the various forms of group therapy are described, the author gives little detail of their actual mechanisms and objectives. In addition, the place of individual psychotherapy is not given the attention that it deserves. There is also some overlap and repetition in the section covering treatment methods.

There are some good data on the association of social strata factors and alcoholism, the welfare programs available, and the variations in the way courts handle each individual case by area and social stratum. The importance of welfare programs is also rightly emphasized and discussed.

Little mention is made of the usefulness of the detoxification center in alcohol treatment programs. The center at the St. Louis State Hospital complex has adequately demonstrated the importance of such centers. The importance of psychiatric and medical complications that may be associated with or follow chronic alcoholism and that may determine the way an alcoholic is handled is not considered.

I wish that the author had given more definitive conclusions and suggestions, based on his experience with the present programs, as to what steps should be taken in the future. There is, in fact, a chapter of summation and recommendations, but it is out of proportion with the large amount of work that has been put into the rest of the book.

There are many useful references, by chapter, to books and other publications, but these are predominantly sociological or epidemiological in nature.

This book should prove most useful to administrators and directors of large community alcohol treatment programs, particularly where such programs are under development.

J.M.C. HOLDEN, M.D.
Nessfield near Ilkley, Yorkshire, England

Here Comes Everybody: Bodymind and Encounter Culture. *By William C. Schutz. New York, Harper & Row, 1971, 292 pp., $6.95.*

The author is a director of the residential program at the Esalen Institute, which indicates that he can speak with considerable authority about encounter groups and related phenomena. As a professional, he was trained in psychology.

The goal of the book, as presented, is "encounter as a culture with its accent on new awareness of the body that is critical to encountering." The book describes "rolfing" and other techniques that propose to reveal the intimate connections between bodily expression and how we think. Elsewhere on the dust jacket the book is described as a "manual for group leaders, a comprehensive, theoretical foundation for the encounter method, and a road map for applying the way of life everywhere."

Encounter culture has its values, as stated by the author, and one can take them or leave them. Much emphasis is placed upon honesty in dealing with others and self-awareness regard-

ing feelings. The author seems to see this as coming about a good deal more easily than a psychiatrist would, especially for those who experience conflict when they become aware of unwanted impulses and feelings. As a theoretical approach to behavior and culture, encounter as presented seems simplistic in its approach to the psychosomatic area and structure of the mind. The exposition of rolfing techniques in approaching mind-body problems will seem both naïve and uninformed to the medical reader. The application of some of these techniques, as described in the book, to patients who have clinical disturbances would seem imprudent at best and unsupported by data that would enable us to discriminate those for whom such techniques would be harmful. As a manual for encounter group leaders the book seems unscientific, in that it makes claims that are unsupported by evidence, and it seems irresponsible in its approach to the problem of selection of leaders and participants in order to negate, as much as possible, the chance of harm to participants.

In a recent, carefully done, controlled study of encounter groups, Yalom and Lieberman showed that 7.5 percent of the participants became casualties as a result of their participation in these groups (1). A disproportionate number of these casualties came from groups led by persons with characteristics described as desirable by Mr. Schutz (high stimulus input, aggressivity, charisma, supportiveness, intrusiveness, and individual—as opposed to interpersonal or group—focus). Dr. Yalom also pointed out that there are people who approach these groups with a low self-concept and unrealistically high expectations and anticipations of change, and it is among these persons that one finds a disproportionate number of casualties. In Mr. Schutz's view, it is the patient's responsibility to screen himself and to look out for himself. This seems to be an undesirable attitude to take when it is clear that many vulnerable people may be tempted to use this technique in an attempt to solve their personal problems. Somehow, it does not seem to be part of the encounter ethic to take such vulnerability into account.

For all of the foregoing reasons, I cannot recommend this book as a scientific document. It is interesting as a presentation of the kind of things that are a part of the encounter phenomena.

REFERENCE

1. Yalom ID, Lieberman MA: A study of encounter group casualties. Arch Gen Psychiatry 25:16–30, 1971

FRANCIS J. KANE, JR., M.D.
New Orleans, La.

The Nurse's Role in Community Mental Health Centers, *by Carol D. DeYoung, R.N., M.S., and Margene Tower, R.N., M.S. St. Louis, C.V. Mosby Co., 1971, 112 pp., $4.90 (paper).*

What is the role of the nurse in the five basic components of the community mental health center? What is considered to be the preparation for the nurse in these areas? What are the possible ways of implementing the results of this study in Colorado? Briefly, these were the questions that a task force of the Colorado Nurses' Association asked a variety of mental health professionals who represented all disciplines. This book is a report of their study. It presents a report of the issues raised by such questions as these in a more candid way than most current literature does.

The authors have raised some very cogent and relevant issues that require examination by all professionals. For example, they point out that a total system change will be needed if nurses are to become an integral part of the community mental health team. In present programs, nurses are still only fully accepted as the member of the inpatient team who gives medications. It seems to me that the authors imply that nurses, who have worked for years to become respected members of inpatient services, are now experiencing what they view as major resistances to their attempts to move into other areas of mental health care.

The authors make it clear that the responses made by the nonnursing subjects in the study indicate that the nurse must aggressively make a place for herself or be left out of the community mental health scene entirely. How else is one to interpret the reaction of one psychiatrist who said that he had never had reason to talk about the role of the nurse in a community mental health center, or the view of the technicians that the nurses' role is much like their own? A social worker's view of the community mental health nurse was tied directly to public health nursing and the care of chronically ill patients. A psychologist did not consider additional formal training beyond basic nursing preparation as necessary for nurses!

The nurses interviewed had difficulty conceptualizing the uniqueness of nursing, although they could describe many nursing activities. Early in their deliberation, discussion came to a dead end, but later they spoke of the "it" or "x" factor in nursing. They felt that this x factor was composed of three elements: regard for the patient, a practical orientation, and the ability to be satisfied with helping.

The final chapter concerns itself with what I consider to be two of the most important issues facing nursing today: primacy of prevention and the role of social action in nursing. The authors propose a model that incorporates "social action as a part of primary prevention as well as caring for the illness component." They also stress the vital importance of nurses becoming skilled in power politics techniques.

In summary, this book helps the reader toward a greater clarification of the nurse's position in present community mental health centers. There is also elucidation of issues that must be considered if the nurse is to become a fully integrated member of a community mental health team. The volume has special relevance for nursing students and nurses who are developing new roles in community mental health nursing. However, the sample is small and the study is a localized one, and therefore it should be replicated on a much broader scale. The book challenges the reader to take another look, perhaps a new look as well, at community mental health, particularly at the quality *and* quantity of the team.

JANICE HITCHCOCK, R.N., M.S.
Rohnert Park, Calif.

This Month's Reviewers

KENNETH L. ARTISS, M.D., is Associate Professor of Psychiatry, Johns Hopkins University School of Medicine, Baltimore, Md., and Teaching Consultant, Psychiatry Training Program, Walter Reed General Hospital, Washington, D.C.

JOHN DONNELLY, M.D., is Psychiatrist-in-Chief, Institute of Living, Hartford, Conn.

VICTOR BLOOM, M.D., is Chief, Adult Inpatient Service, Lafayette Clinic, and Associate Professor, Department of Psychiatry, Wayne State University School of Medicine, Detroit, Mich.

FREDERICK LEMERE, M.D., is Clinical Professor of Psychiatry, University of Washington School of Medicine, Seattle, Wash.

IAGO GALDSTON, M.D., is Director, Psychiatric Resident Training, Connecticut State Department of Mental Health, Hartford, Conn.

CHARLES E. HENRY, PH.D., is Director, EEG Laboratory, Cleveland Clinic, Cleveland, Ohio.

STUART M. FINCH, M.D., is Professor of Psychiatry, University of Michigan Medical School, Ann Arbor, Mich.

E. FULLER TORREY, M.D., is Special Assistant to the Director for International Activities, National Institute of Mental Health, Rockville, Md.

SAMUEL I. STONE, PH.D., is Professor Emeritus of French Literature, Boston University, Boston, Mass.

J.M.C. HOLDEN, M.D., is Consultant Psychiatrist, Middlewood and United Sheffield Hospitals, University of Sheffield and North Sheffield, Sheffield, England.

FRANCIS J. KANE, JR., M.D., is Medical Director, DePaul Hospital, and Clinical Professor of Psychiatry, Tulane University School of Medicine, New Orleans, La.

JANICE HITCHCOCK, R.N., M.S., is Assistant Professor, Department of Nursing, Sonoma State College, Rohnert Park, Calif.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reveiwed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

The Black Box: An Excursion Into Inner Sensory Perception, *by Robert H. Adleman. Los Angeles, Nash Publishing, 1973, 170 pp., $7.95.*

The Future of Pharmacotherapy: New Drug Delivery Systems, *edited by Frank J. Ayd, Jr., M.D. Baltimore, International Drug Therapy Newsletter, 1973, 115 pp., $6.*

Beyond Words: The Story of Sensitivity Training and the Encounter Movement, *by Kurt W. Back, Ph.D. Baltimore, Penguin Books, 1973, 255 pp., $1.75 (paper).*

Children and Their Parents in Brief Therapy, *edited by Harvey H. Barten, M.D., and Sybil S. Barten, Ph.D. New York, Behavioral Publications, 1973, 323 pp., $9.95.*

Mental Health Consultation and Education, *by Arnold R. Beisser, M.D., with Rose Green, M.S.S. Palo Alto, Calif., National Press Books, 1972, 153 pp., $4.95.*

The Homeless Mind: Modernization and Consciousness, *by Peter L. Berger, Brigitte Berger, and Hansfried Kellner. New York, Random House, 1973, 249 pp., $6.95.*

Drug Dealers—Taking Action, *by Richard H. Blum and associates. San Francisco, Jossey-Bass, 1973, 307 pp., $10.75.*

Music and Your Mind, *by Helen L. Bonny, M.Mus.Ed., and Louis M. Savary, Ph.D., S.T.D. New York, Harper & Row, 1973, 131 pp. plus appendices, $5.95.*

An Elementary Textbook of Psychoanalysis, revised ed., *by Charles Brenner, M.D. New York, International Universities Press, 1973, 274 pp., $7.95.*

Psychiatrists in Training. *The Report of the Royal Medico-Psychological Association's Manpower and Education Project. British Journal of Psychiatry Special Publication No. 7, by Peter Brook. Ashford, Kent, England, Headley Brothers, 1973, 163 pp., $5.35 (paper).*

Beyond the Information Given: Studies in the Psychology of Knowing, *by Jerome S. Bruner, edited by Jeremy M. Anglin. New York, W.W. Norton & Co., 1973, 490 pp., $13.95.*

Psychiatric Nursing in the Hospital and the Community, *by Ann C. Burgess, R.N., D.N.Sc., and Aaron Lazare, M.D. Englewood Cliffs, N.J., Prentice-Hall, 1973, 417 pp., $8.95.*

Mental Illness in Later Life, *edited by Ewald W. Busse, M.D., and Eric Pfeiffer, M.D. Washington, D.C., American Psychiatric Association, 1973, 293 pp., $9, hardcover; $7, paper.*

Drug Abuse in Industry, *by Pasquale A. Carone, M.D., and Leonard W. Krinsky, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 163 pp., $11.50.*

Teachers Are People, revised ed., *by Virginia Church. Santa Barbara, Calif., Wallace Hebberd, 1973, 82 pp., $3.50.*

School Intervention, *edited by William L. Claiborn, Ph.D., and Robert Cohen, Ph.D. New York, Behavioral Publications, 1973, 265 pp., $7.95.*

Psychopathology and Psychopharmacology: Proceedings of the Sixty-Second Annual Meeting of the American Psychopathological Association, New York City, March 1972, *edited by Jonathan O. Cole, Alfred M. Freedman, and Arnold J. Friedhoff. Baltimore, Johns Hopkins University Press, 1973, 288 pp., $15.*

Jail House Blues: Studies of Suicidal Behavior in Jail and Prison, *by Bruce L. Danto, M.D. Orchard Lake, Mich., Epic Publications, 1973, 320 pp., $8.95.*

Die erblichen myoklonisch-epileptisch-dementiellen Kernsyndrome, *by Klaus Diebold. New York, Springer-Verlag, 1973, 249 pp., $36.30.*

The Anatomy of Dependence, *by Takeo Doi, M.D., translated by John Bester. New York, Kodansha International, 1973, 170 pp., $7.95.*

Psychological Perspectives on Population, *edited by James T. Fawcett. New York, Basic Books, 1973, 512 pp., $15.*

The Writings of Anna Freud, vol. 3: Infants Without Families: Reports on the Hampstead Nurseries, 1939–1945. *New York, International Universities Press, 1973, 666 pp., $17.50.*

Psychopharmacological Agents for the Terminally Ill and Bereaved, *edited by Ivan K. Goldberg, Sidney Malitz, and Austin H. Kutscher. New York, Columbia University Press (distributor), 1973, 326 pp., $12.50.*

Out-of-the-Body Experiences (1968), *by Celia Green, New York, Ballantine Books, 1973, 165 pp., $1.25 (paper).*

Mental Institutions in America: Social Policy to 1875, *by Gerald N. Grob. New York, Free Press, Macmillan Co., 1973, 436 pp., $10.95.*

The Joys and Sorrows of Parenthood, *by the Group for the Advancement of Psychiatry, report no. 84. New York, GAP, 1973, 138 pp., $4 (paper).*

Public and Private Lives of Psychotherapists, *by William E. Henry, John H. Sims, and S. Lee Spray. San Francisco, Jossey-Bass, 1973, 263 pp., $12.50.*

I.Q. in the Meritocracy, *by R.J. Herrnstein. Boston, Little, Brown and Co., 1973, 230 pp., $7.95.*

I'll Quit Tomorrow, *by Vernon E. Johnson. New York, Harper & Row, 1973, 168 pp., $5.95.*

Childhood Psychosis: Initial Studies and New Insights, *by Leo Kanner, M.D. New York, Halsted Press, John Wiley & Sons (distributor), 1973, 283 pp., $10.95.*

The Unspoken Motive: A Guide to Psychoanalytic Literary Criticism, *by Morton Kaplan, Ph.D., and Robert Kloss, Ph.D. New York, Free Press, Macmillan Co., 1973, 313 pp., $8.95.*

Women in the Work Force: Proceedings of a Conference, *edited by Mildred E. Katzell, Ph.D., and William C. Byham, Ph.D. New York, Behavioral Publications, 1972, 76 pp., $7.95.*

The Psychology of Obesity: Dynamics and Treatment, *edited by Norman Kiell. Springfield, Ill., Charles C Thomas, 1973, 444 pp., $13.95.*

Sex & Birth Control: A Guide for the Young, *by E. James Lieberman, M.D., and Ellen Peck. New York, Thomas Y. Crowell Co., 1973, 287 pp., $5.95.*

The Early Window: Effects of Television on Children and Youth, *by Robert M. Liebert, Ph.D., John M. Neale, Ph.D., and Emily S. Davidson. New York, Pergamon Press, 1973, 185 pp., no price listed (paper).*

Behavioral Science and Modern Penology: A Book of Readings, *edited by William H. Lyle, Jr., Ph.D., and Thetus W. Horner. Springfield, Ill., Charles C Thomas, 1973, 355 pp., $11.95.*

Teaching Educable Mentally Retarded Children: Methods and Materials, *by James C. Mainord, Ph.D., and Harold D. Love, Ed.D. Springfield, Ill., Charles C Thomas, 1973, 260 pp., $8.95.*

Time-Limited Psychotherapy, *by James Mann, M.D. Cambridge, Mass., Harvard University Press, 1973, 199 pp., $7.95.*

Psychological Consultation with a Police Department, *by Philip A. Mann, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 162 pp., $9.50.*

Psychotherapy and Behavior Change: 1972, *edited by Isaac M. Marks, Allen E. Bergin, Peter J. Lang, Joseph D. Matarazzo, Gerald R. Patterson, and Hans H. Strupp. Chicago, Aldine Publishing Co., 1973, 497 pp., $20.*

Psychoanalysis and Women, *edited by Jean Baker Miller, M.D. Baltimore, Penguin Books, 1973, 415 pp., $2.95 (paper).*

Industrial Mental Health and Employee Counseling, *compiled and edited by Robert L. Noland. New York, Behavioral Publications, 1973, 432 pp., $16.95.*

Head Start: A Tragicomedy with Epilogue, *by James S. Payne, Ed.D., Ruth A. Payne, Cecil D. Mercer, M.S., and Roxana G. Davison. New York, Behavioral Publications, 1973, 253 pp., $4.95 (paper).*

The Gestalt Approach & Eye Witness to Therapy, *by Fritz Perls, M.D., Ph.D. Ben Lomond, Calif., Science & Behavior Books, 1973, 206 pp., $6.95.*

Gestalt Therapy Integrated: Contours of Theory and Practice, *by Erving Polster, Ph.D., and Miriam Polster, Ph.D. New York, Brunner/Mazel, 1973, 319 pp., $12.50.*

Counselling in Religion and Psychiatry, *by Desmond Pond. New York, Oxford University Press, 1973, 81 pp., $4.*

Abstracts of the Standard Edition of the Complete Psychological Works of Sigmund Freud, *edited by Carrie Lee Rothgeb. New York, International Universities Press, 1973, 761 pp., $20.*

The Experimental Psychology of Mental Retardation, *edited by Donald K. Routh, Ph.D. Chicago, Aldine Publishing Co., 1973, 335 pp., $10.50.*

The Botany and Chemistry of Hallucinogens, *by Richard Evans Schultes, Ph.D., and Albert Hofmann, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 251 pp., $14.75.*

The Transforming Self: New Dimensions in Psychoanalytic Process, *by David Shainberg, M.D. New York, Intercontinental Medical Book Corp., 1973, 148 pp., no price listed.*

Biofeedback and Self-Control: 1972, *edited by David Shapiro, T.X. Barber, Leo V. DiCara, Joe Kamiya, Neal E. Miller, and Johann Stoyva. Chicago, Aldine Publishing Co., 1973, 517 pp., $16.*

The Urban Policeman in Transition: A Psychological and Sociological Review, *by John R. Snibbe, Ph.D., and Homa M. Snibbe, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 610 pp., no price listed.*

Clinical Studies in Childhood Psychoses, *edited by S.A. Szurek, M.D., and I.N. Berlin, M.D. New York, Brunner/ Mazel, 1973, 767 pp., $20.*

Childhood Learning, Behavior, and the Family, *by Louise C. Taichert, M.D. New York, Behavioral Publications, 1973, 108 pp., $7.95.*

Crime and Insanity in England, vol. 2: New Solutions and New Problems, *by Nigel Walker and Sarah McCabe. Chicago, Aldine · Atherton, 1973, 292 pp., $12.50.*

Help for the Handicapped Child, *by Florence Weiner. New York, McGraw-Hill Book Co., 1973, 212 pp., $7.95.*

The Hyperactive Child: A Handbook for Parents, *by Paul H. Wender, M.D. New York, Crown Publishers, 1973, 114 pp., $3.95.*

Mental Retardation and Developmental Disabilities, An Annual Review: V, *edited by Joseph Wortis, M.D. New York, Brunner/ Mazel, 1973, 214 pp., no price listed.*

The Principles of Medical Ethics
With Annotations Especially Applicable to Psychiatry

The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry

This statement was approved by the Assembly of District Branches and the Board of Trustees of the American Psychiatric Association at their May 5–6, 1973, meetings, upon recommendation of the Committee on Ethics.[1]

FOREWORD

ALL PHYSICIANS should practice in accordance with the medical code of ethics set forth in the Principles of Medical Ethics of the American Medical Association. An up-to-date expression and elaboration of these statements is found in the *Opinions and Reports of the Judicial Council* of the American Medical Association (1). Psychiatrists are strongly advised to be familiar with these documents.[2]

However, these general guidelines have sometimes been difficult to interpret for psychiatry, so further annotations to the basic principles are offered in this document. While psychiatrists have the same goals as all physicians, there are special ethical problems in psychiatric practice that differ in coloring and degree from ethical problems in other branches of medical practice, even though the basic principles are the same. The annotations are not designed as absolutes and will be revised from time to time so as to be applicable to current practices and problems. Although the material appears in this form for the first time, it is derived from the work of many committees and task forces over the years.

Following are the AMA Principles of Medical Ethics, printed in their entirety, and then each principle printed separately along with an annotation especially applicable to psychiatry.

[1] The committee included C.H. Hardin Branch, M.D., Chairman, Herbert Klemmer, M.D., Robert A. Moore, M.D., Robert P. Nenno, M.D., Alex D. Pokorny, M.D., Charles D. Prudhomme, M.D., Joseph S. Skobba, M.D., and Gene Usdin, M.D. William P. Camp, M.D., and Byron A. Eliashof, M.D., were members of the subcommittee that aided in the preparation of these annotations, and William A. Bellamy, M.D., was special consultant.

[2] Chapter 8, Section 1 of the By-Laws of the American Psychiatric Association states: "All members of the American Psychiatric Association shall be bound by the ethical code of the medical profession especially defined in the Principles of Medical Ethics of the American Medical Association."

PRINCIPLES OF MEDICAL ETHICS, AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Principles with Annotations

Following are each of the AMA Principles of Medical Ethics printed separately along with an annotation especially applicable to psychiatry.

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.[3]

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

The patient may place his trust in his psychiatrist knowing that the psychiatrist's ethics and professional responsibilities preclude him from gratifying his own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.

The requirement that the physician "conduct himself with propriety in his profession and in all the actions of his life" is especially important in the case of the psychiatrist because the patient tends to model his behavior after that of his therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. Sexual activity with a patient is unethical.

The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.

Physicians generally agree that the doctor-patient relationship is such a vital factor in effective treatment of the patient that preservation of optimal conditions for development of a sound working relationship between a doctor and his patient should take precedence over all other considerations. Professional courtesy may lead to poor psychiatric care for physicians and their families because of embarrassment over the lack of a complete give-and-take contract.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

SECTION 3

A physician should practice a method of healing founded on a scientific basis and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

It would seem self-evident that a psychiatrist who is a lawbreaker might be ethically unsuited to practice his profession. When such illegal activities bear directly upon his practice, this would obviously be the case. However, in other instances, illegal activities such as those concerning the right to protest social injustices might not bear on either the image of the psychiatrist or the ability of the specific psychiatrist to treat his patient ethically and well. While no committee or board could offer prior assurance that any illegal activity would not be considered unethical, it is conceivable that an individual could violate a law without being guilty of professionally unethical behavior. Physicians lose no right of citizenship on entry into the profession of medicine.

A psychiatrist who regularly practices outside his area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.

Special consideration should be given to those psychiatrists who, because of mental illness, jeopardize the welfare of their patients and their own reputations and practices. It is ethical, even encouraged, for another psychiatrist to intercede in such situations.

SECTION 5

A physician may choose whom he will serve. In an

[3] Statements in italics are taken directly from the American Medical Association's Principles of Medical Ethics or annotations thereto (1).

emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

A psychiatrist should not be a party to any type of policy that excludes, segregates, or demeans the dignity of any patient because of ethnic origin, race, sex, creed, age, or socioeconomic status.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision, or individual whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, for a salary, or for a fixed rate per capita.

Contract practice per se is not unethical. Contract practice is unethical if it permits features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

The ethical question is not the contract itself but whether or not the physician is free of unnecessary nonmedical interference. The ultimate issue is his freedom to offer good quality medical care.

In relationships between psychiatrists and practicing licensed psychologists, the physician should not delegate to the psychologist or, in fact, to any nonmedical person any matter requiring the exercise of professional medical judgment.

When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if he allows himself to be used as a figurehead.

In the practice of his specialty, the psychiatrist consults, associates, collaborates, or integrates his work with that of many professionals, including psychologists, psychometricians, social workers, alcoholism counselors, marriage counselors, public health nurses, etc. Furthermore, the nature of modern psychiatric practice extends his contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he is dealing is a recognized member of his own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he refers patients. Whenever he has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him.

Also, he should neither lend the endorsement of the psychiatric specialty nor refer patients to persons, groups, or treatment programs with which he is not familiar, especially if their work is based only on dogma and authority and not on scientific validation and replication.

In accord with the requirements of law and accepted medical practice, it is ethical for a physician to submit his work to peer review and to the ultimate authority of the medical staff executive body and the hospital administration and its governing body.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

The psychiatrist may also receive income from administration, teaching, research, education, and consultation.

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if a patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his circumstances.[4]

Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement

[4] This paragraph is reprinted as an annotation to Section 7 in the AMA's *Opinions and Reports of the Judicial Council* (1, p. 39).

between the patient and the treating physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

It is ethical for the psychiatrist to make a charge for a missed appointment when this falls within the terms of the specific contractual agreement with the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of the medical service may be enhanced thereby.

The psychiatrist should agree to the request of a patient for consultation or to such a request from the family of an incompetent or minor patient. The psychiatrist may suggest possible consultants, but the patient or family should be given free choice of the consultant. If the psychiatrist disapproves of the professional qualifications of the consultant or if there is a difference of opinion that the primary therapist cannot resolve he may, after suitable notice, withdraw from the case. If this disagreement occurs within an institution or agency framework, the differences should be resolved by the mediation or arbitration of higher professional authority within the institution or agency.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. Confidentiality is essential to psychiatric treatment. This is based in part on the special nature of psychiatric therapy as well as on the traditional ethical relationship between physician and patient. Growing concern regarding the civil rights of patients and the possible adverse effects of computerization, duplication equipment, and data banks makes the dissemination of confidential information an increasing hazard. Because of the sensitive and private nature of the information with which the psychiatrist deals, he must be circumspect in the information that he chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration.

A psychiatrist may release confidential information only with the authorization of the patient or under proper legal compulsion. The continuing duty of the psychiatrist to protect the patient includes fully apprising him of the connotations of waiving the privilege of privacy. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action. The same principles apply to the release of information concerning treatment to medical departments of government agencies, business organizations, labor unions, and insurance companies. Information gained in confidence about patients seen in student health services should not be released without the student's explicit permission.

Clinical and other materials used in teaching and writing must be adequately disguised in order to preserve the anonymity of the individuals involved.

The ethical responsibility of maintaining confidentiality holds equally for the consultations in which the patient may not have been present and in which the consultee was not a physician. In such instances, the physician consultant should alert the consultee to his duty of confidentiality.

Ethically the psychiatrist may disclose only that information which is immediately relevant to a given situation. He should avoid offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary.

Psychiatrists are often asked to examine individuals for security purposes, to determine suitability for various jobs, and to determine legal competence. The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.

Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient.

Careful judgment must be exercised by the psychiatrist in order to include, when appropriate, the parents or guardian in the treatment of a minor. At the same time the psychiatrist must assure the minor proper confidentiality.

When the psychiatrist is ordered by the court to reveal the confidences entrusted to him by patients he may comply or he may ethically hold the right to dissent within the framework of the law. When the psychiatrist is in doubt, the right of the patient to confidentiality and, by extension, to unimpaired treatment, should be given priority. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only that information which is relevant to the legal question at hand.

SECTION 10

The honored ideals of the medical profession im-

ply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Psychiatrists should foster the cooperation of those legitimately concerned with the medical, psychological, social, and legal aspects of mental health and illness. Psychiatrists are encouraged to serve society by advising and consulting with the executive, legislative, and judiciary branches of the government. A psychiatrist should clarify whether he speaks as an individual or as a representative of an organization. Furthermore, psychiatrists should avoid clouding their public statements with the authority of the profession (e.g., "Psychiatrists know that. . .").

Psychiatrists may interpret and share with the public their expertise in the various psychosocial issues that may affect mental health and illness. Psychiatrists should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine.

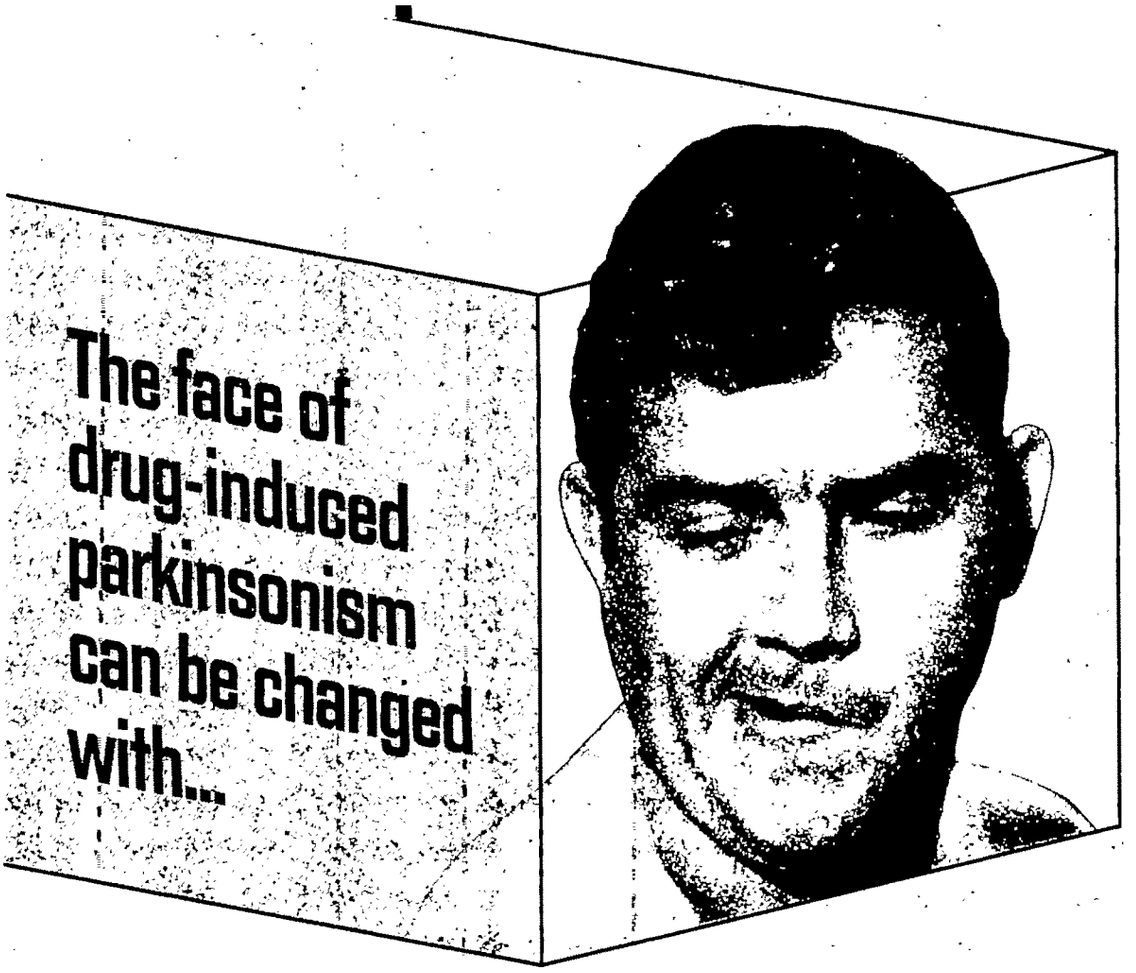
On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention, or who has disclosed information about himself through public media. It is unethical for a psychiatrist to offer a diagnosis unless he has conducted an examination and has been granted proper authorization for such a statement.

The psychiatrist should not permit his certification to be used for the involuntary commitment of any person except when this is clearly necessary for the patient's own protection or the protection of others from probable injury at the patient's hands.

"A complaint concerning the behavior of a member of this Association shall be in writing, signed by the complainant, and filed with the Secretary." (Chapter 10, Section 1, By-Laws, American Psychiatric Association.)

REFERENCE

1. Judicial Council, American Medical Association: Opinions and Reports of the Judicial Council. Chicago, AMA, 1971

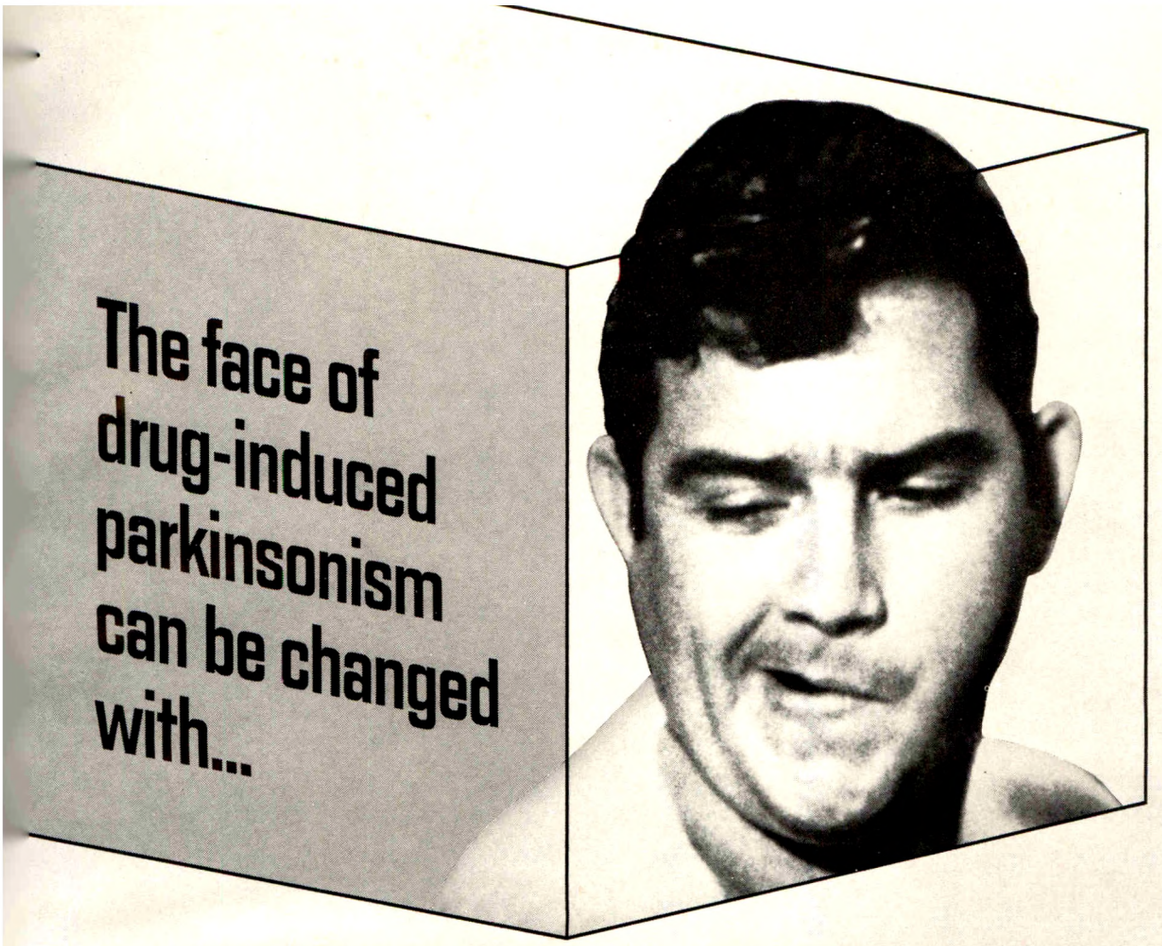


AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally; **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA

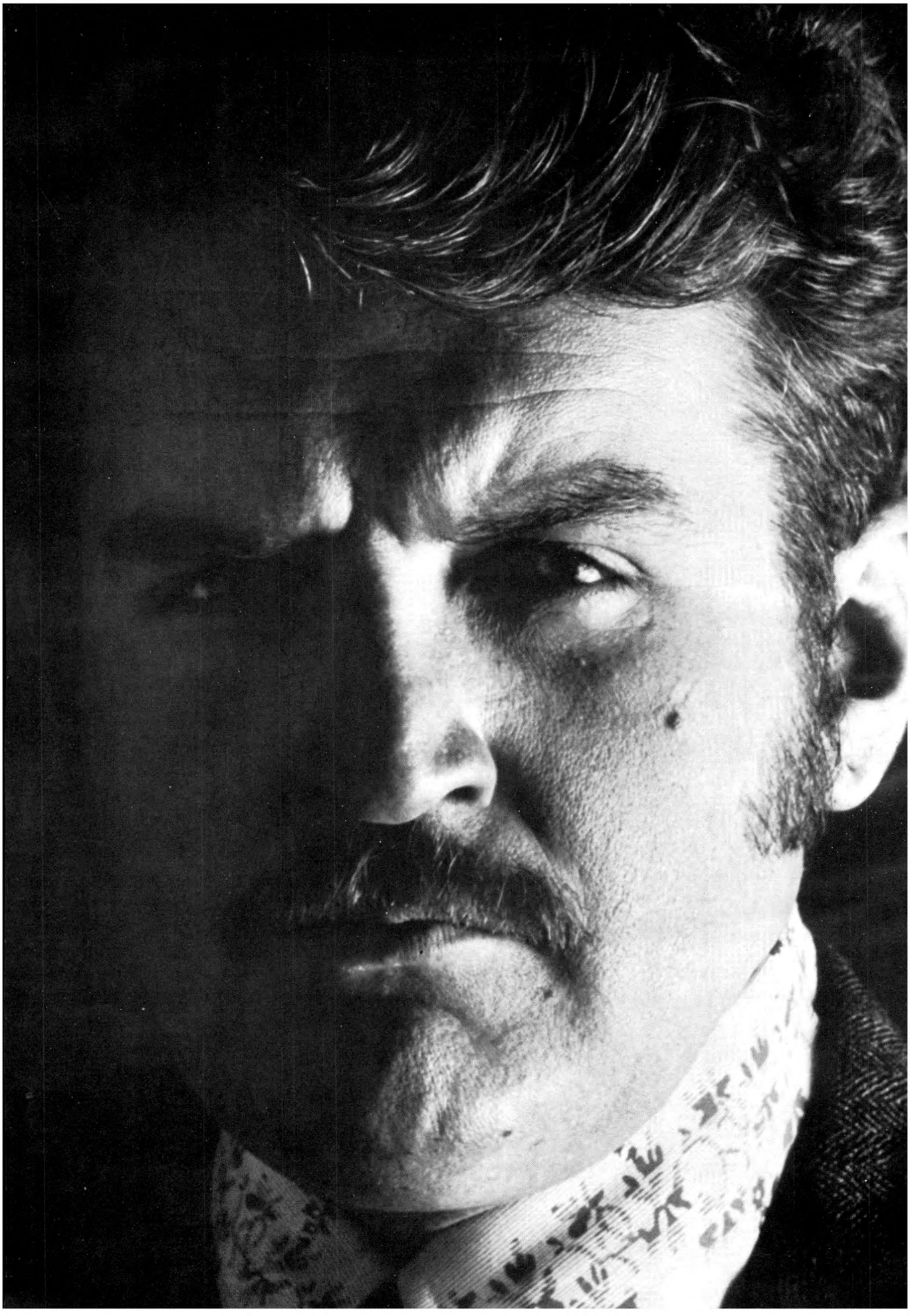


AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally: **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA



The hostile patient.

He vacillates from suspiciousness to rage.
His disorientation is apparent through
his erratic outbursts against imagined enemies.

His irrational behavior worries his family.
And hinders your treatment.
How do you reach him?

Very possibly, with QUIDE (piperacetazine).

Clinical studies of schizophrenic patients on a regimen of QUIDE have demonstrated moderate to excellent improvement in mental status and remission of hyperactive, combative behavior. Improvement in interpersonal relationships and adjustment to therapy were especially notable.

In clinical evaluation, although extrapyramidal reactions did occur, the low incidence of these reactions allowed for patient cooperation.

When Parkinsonism did occur, it was easily controlled by modification of dosage or, infrequently, the addition of an anti-Parkinson agent. Photosensitivity rarely occurred.

QUIDE (piperacetazine) . . . it may well be what some of your patients are waiting for.

Quide® tablets
piperacetazine

DOW **DOW PHARMACEUTICALS** The Dow Chemical Company Indianapolis, Indiana

See next page for complete prescribing information.

Quide® tablets
piperacetazine

DESCRIPTION: QUIDE (piperacetazine) is a piperidine derivative of phenothiazine.

Piperacetazine has the following chemical designation: 10- { 3-[4-(2-Hydroxyethyl)-piperidino]propyl } phenothiazin-2-yl Methyl Ketone.

ACTIONS: The exact mode of action of the phenothiazines is unclear, but drugs of this class produce changes at all levels of the central nervous system, as well as on multiple organ systems.

INDICATIONS: QUIDE is indicated for use in the management of the manifestations of psychotic disorders.

CONTRAINDICATIONS: QUIDE is contraindicated in patients who are comatose or markedly depressed from any cause and in the presence of preexisting thrombocytopenia and other blood dyscrasias, bone marrow depression and in patients with significant liver disease. QUIDE is contraindicated in women who are or may become pregnant since animal reproductive studies adequate to establish safety during pregnancy have not been carried out. QUIDE is contraindicated in patients who have shown hypersensitivity to the drug. Cross sensitivity between phenothiazine derivatives may occur.

WARNING: Like other phenothiazines, QUIDE may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, patients should be cautioned accordingly. Concomitant use with alcohol should be avoided due to the potential additive effect. Patients with known suicidal tendencies should not be given QUIDE except under strict medical supervision.

Use in Children: The use of QUIDE in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Use with caution in persons who:

1. are receiving barbiturates or narcotics, because of additive effects on central nervous system depression. The dosage of the narcotic or barbiturate should be reduced when given concomitantly with QUIDE.
2. are receiving atropine or related drugs, because of additive anticholinergic effects.
3. have a history of epilepsy, because this drug may lower the convulsive threshold. Adequate anticonvulsant therapy must be maintained concomitantly.
4. are exposed to extreme heat or phosphorous insecticides.
5. have a history of peptic ulcer. Aggravation of preexisting ulcer has occurred.
6. have cardiovascular disease.
7. have respiratory impairment due to acute pulmonary infections or chronic respiratory disorders such as severe asthma or emphysema.

Keep in mind that the antiemetic effect may mask the toxicity of other drugs or obscure the diagnosis of such conditions as intestinal obstruction or brain tumor.

Any sign of blood dyscrasias requires immediate discontinuance of the drug and the institution of appropriate therapy.

The possibility of liver damage, pigmentary retinopathy, lenticular or corneal deposits, and development of irreversible dyskinesias should be kept in mind when patients are on prolonged therapy.

Abrupt Withdrawal: In general, phenothiazines do not produce psychic dependence, but gastritis, nausea and vomiting, dizziness and tremulousness have been reported following abrupt cessation of high-dose therapy. Reports suggest that these symptoms can be reduced if concomitant antiparkinson agents are continued for several weeks after the phenothiazine is withdrawn.

ADVERSE REACTIONS: Not all of the following adverse reactions have been reported with QUIDE (piperacetazine), but pharmacological similarities among various phenothiazine derivatives require that each be considered.

Note: Sudden Death has occasionally been reported in patients who have received phenothiazines. In some cases death was apparently due to cardiac arrest, in others the cause appeared to be asphyxia due to failure of the cough reflex. In some patients the cause could not be determined, nor could it be established that death was due to the phenothiazine.

Drowsiness: May occur particularly during the first or second week, after which it generally disappears. If troublesome, lower the dosage.

Jaundice: Incidence is low. When it occurs (usually between the second and fourth weeks of therapy) it is generally regarded as a sensitivity reaction. The clinical picture resembles infectious hepatitis with laboratory features of obstructive jaundice. It is usually reversible although chronic jaundice has been reported with phenothiazine therapy.

Hematological Disorders: Agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenia purpura and pancytopenia.

Agranulocytosis: Most cases have occurred between the fourth and tenth weeks of therapy. Patients should be watched closely during that period for the sudden appearance of sore throat or other signs of infection. If white blood count and differential show significant cellular depression, discontinue the drug and start appropriate therapy. A slightly lowered white count, however, is not in itself an indication to discontinue the drug.

Cardiovascular: Postural hypotension, tachycardia (especially following rapid increase in dosage), bradycardia, cardiac arrest, faintness and dizziness. Occasionally the hypotensive effect may produce a shock-like condition. In the event a vasoconstrictor is required, levarterenol and phenylephrine are the most suitable. Other pressor agents, including epinephrine, should not be used because a paradoxical further lowering of the blood pressure may ensue.

EKG changes, nonspecific, usually reversible, have been observed in some patients receiving phenothiazine tranquilizers. Their relationship to myocardial damage has not been confirmed.

CNS Effects: Neuromuscular (extrapyramidal) Reactions: These are usually dose related and take three forms: (1) pseudoparkinsonism; (2) akathisia; and (3) dystonias (Dystonias include spasms of the neck muscles, extensor rigidity of back muscles, carpopedal spasm, eyes rolled back, convulsions, trismus and swallowing difficulties). These resemble serious neurological disorders but usually subside within 48 hours. Management of the extrapyramidal symptoms, depending upon the type and severity, includes sedation, injectable diphenhydramine, and the use of antiparkinsonism agents.

Hyperreflexia has been reported in the newborn when a phenothiazine was used during pregnancy.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, tardive dyskinesia may appear in some patients on long-term therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of the mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; anti-parkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Other CNS Effects: Cerebral edema. Abnormality of cerebral spinal fluid proteins. Convulsive seizures, particularly in patients with EEG abnormalities or a history of such disorders. Hyperpyrexia.

Adverse Behavioral Effects: Paradoxical exacerbation of psychotic symptoms.

Allergic Reactions: Urticaria, itching, erythema, photosensitivity (avoid undue exposure to the sun) eczema. Severe reactions include: exfoliative dermatitis (rare); contact dermatitis in nursing personnel administering the drug; asthma; laryngeal edema; angioneurotic edema; and anaphylactoid reactions.

Endocrine Disorders: Lactation and moderate breast engorgement in females and gynecomastia in males on large doses; changes in libido; false-positive pregnancy tests; amenorrhea; hyperglycemia, hypoglycemia, glycosuria.

Autonomic Reactions: Dry mouth, nasal congestion, constipation, adynamic ileus, myosis, mydriasis, urinary retention.

Special Considerations in Long-term Therapy: After prolonged administration of phenothiazines, pigmentation of the skin has occurred chiefly in the exposed areas, especially in females on large doses. Ocular changes consisting of deposition of fine particulate matter in the cornea and lens, progressing in more severe cases to star-shaped lenticular opacities; epithelial keratopathies; pigmentary retinopathy.

Other Adverse Reactions: Increases in appetite and weight; peripheral edema.

DOSAGE AND ADMINISTRATION: Dosage should be individualized, not only initially but during the course of therapy, and the minimal effective dose should always be employed. A starting dosage of 10 mg. two to four times daily is recommended for adults. The dose may be increased up to 160 mg. daily within a three to five day period. Should side effects occur, dosage should be reduced or discontinued as indicated. For maintenance therapy, up to 160 mg. daily in divided doses may be given.

OVERDOSAGE WITH PHENOTHIAZINES:
Manifestations: One of three clinical pictures may be seen.

1. Extreme somnolence; patient can usually be roused with prodding, but if permitted will fall asleep. General condition is usually satisfactory. The skin, though pale, is warm and dry. Slight blood pressure, respiratory and pulse changes may occur but are not problems.
2. Mild to moderate drop in blood pressure (patient may be conscious or unconscious). Skin is markedly gray but warm and dry. Nail beds are pink. Respiration is slow and regular. Pulse is strong but rate slightly increased.
3. Severe hypotension, possibly accompanied by weakness, cyanosis, perspiration, rapid thready pulse and respiratory depression.

Treatment: Is essentially symptomatic and supportive. Early gastric lavage and intestinal purges may help. Centrally acting emetics may not help because of the possible antiemetic effect of QUIDE. Give hot tea or coffee. Severe hypotension usually responds to measures described under hypotensive effects (see ADVERSE REACTIONS: *Cardiovascular).* Additional measures include pressure bandages to lower limbs, oxygen and I.V. fluids.

Avoid stimulants that may cause convulsions (e.g., picrotoxin and pentylenetetrazol).

Limited experience with dialysis indicates that it is not helpful.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED:

QUIDE (piperacetazine) Tablets—10 mg. (orange)–bottles of 100 (NDC 183-52-2), and bottles of 1000 (NDC 183-52-4).

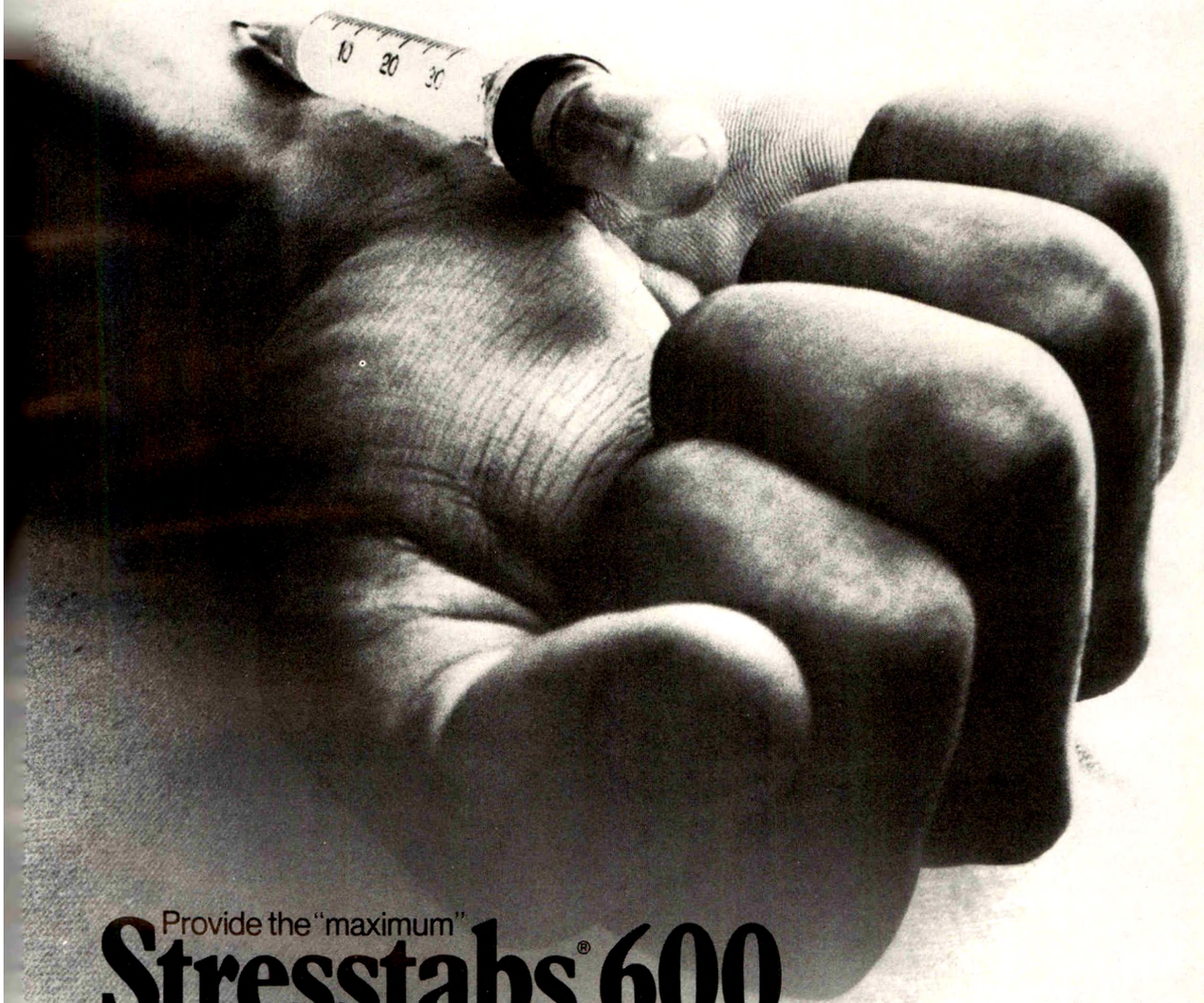
QUIDE (piperacetazine) Tablets—25 mg. (yellow)–bottles of 100 (NDC 183-53-2), and bottles of 1000 (NDC 183-53-4).

Note: Dispense only in light-resistant containers; the coatings on these tablets contain light-sensitive colors.

January 1973

DOW **DOW PHARMACEUTICALS** The Dow Chemical Company Indianapolis, Indiana

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

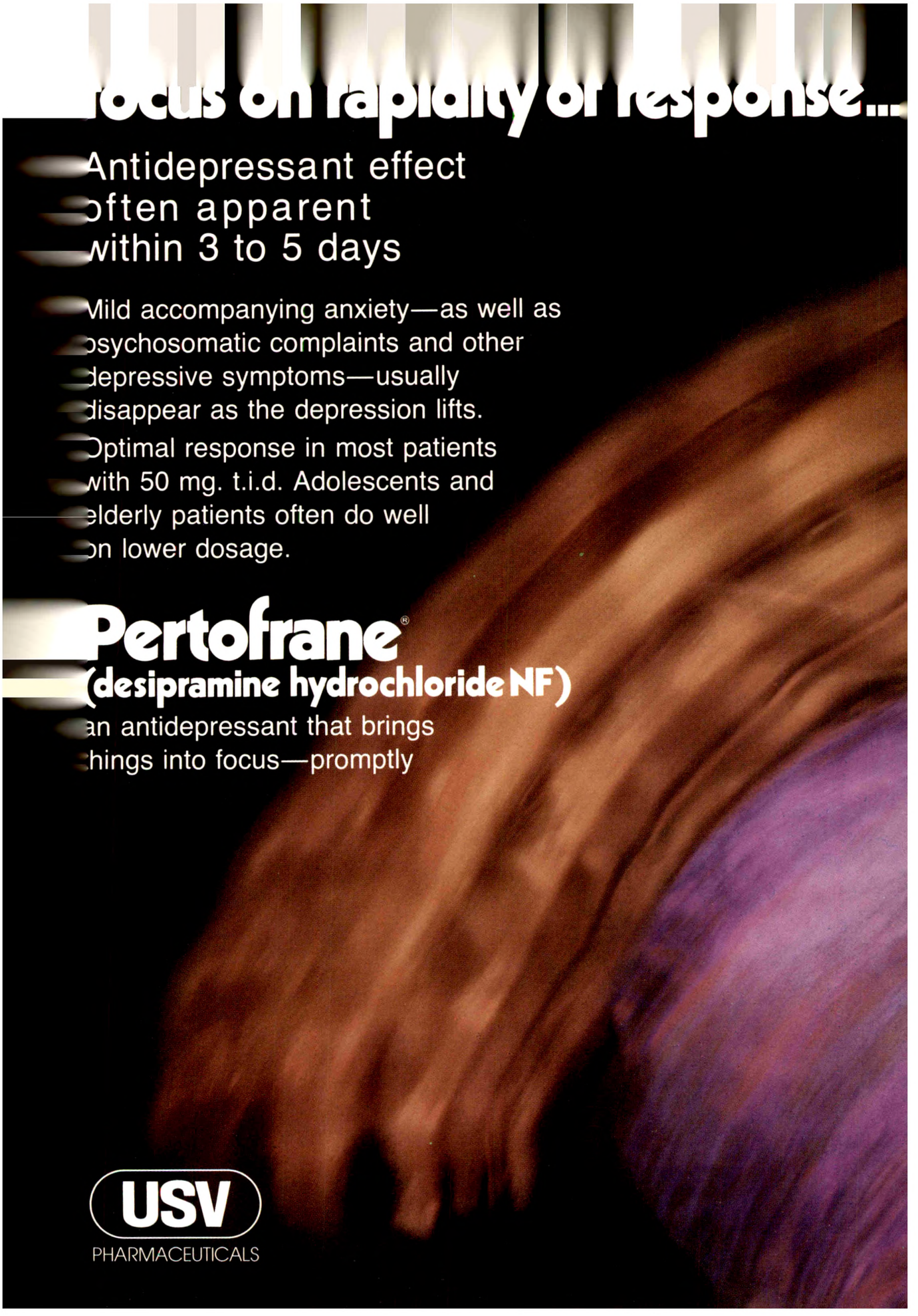
High Potency Stress Formula Vitamins

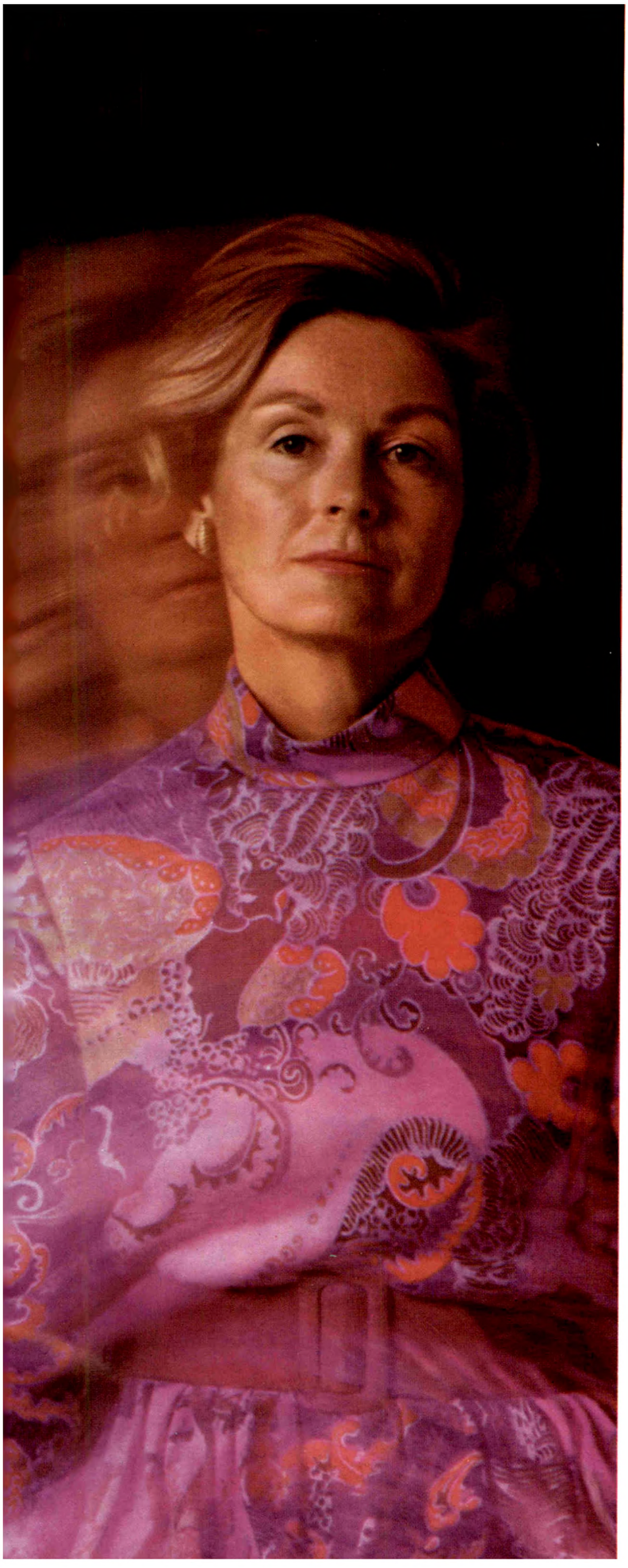
Each Tablet Contains:

Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3


Focus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS



Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707

This man will self-destruct...



ALCOHOLISM

shortens the abuser's life-span by 10 to 12 years*

Private problem/ Public menace

Besides having a shortened life expectancy, the alcoholic is roughly twice as likely to develop hypertension, ulcers, or cerebrovascular disease; 29 times as likely to develop cirrhosis of the liver; and 58 times as apt to commit suicide as the non-alcoholic. Moreover, an estimated 28,000 automobile deaths each year involve drinking drivers, and alcohol addiction, directly or indirectly, causes almost half of all the crimes in this country.

ANTABUSE® (disulfiram) when he's ready for help

For almost 25 years, ANTABUSE has proved its effectiveness as a medical adjunct in the management of alcoholics who are motivated to recover. ANTABUSE offers strong deterrent action to help them maintain sobriety and participate in a total treatment program, including supportive measures such as psychotherapy and/or concerned people, agencies, or organizations (e.g., Alcoholics Anonymous).

When you prescribe ANTABUSE and the alcoholic patient accepts it, he strengthens his resolve to stop drinking with each daily tablet he takes. If he drinks while the ANTABUSE effect remains in his bloodstream, he will become intensely ill. **The patient must be given a clear and detailed account of the effects of ingesting even a small amount of alcohol after he has taken ANTABUSE, and must be told that such effects may occur even up to 14 days after the last dose.** This factor deters impulsive drinking, shores up the patient's resolve, and helps enforce his sobriety. And, since ANTABUSE is nonhabituating, there's no chance of cross-addiction...a decided advantage in helping the motivated alcoholic stay on a long-term rehabilitation program.

*According to the National Institute on Alcohol Abuse and Alcoholism, alcohol abusers are estimated to shorten their life-span by an average of 10 to 12 years.

BRIEF SUMMARY
(For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) In Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, *e.g.* cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

ANTABUSE®
Brand of DISULFIRAM

A strong deterrent for the alcoholic who doesn't want to drink

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

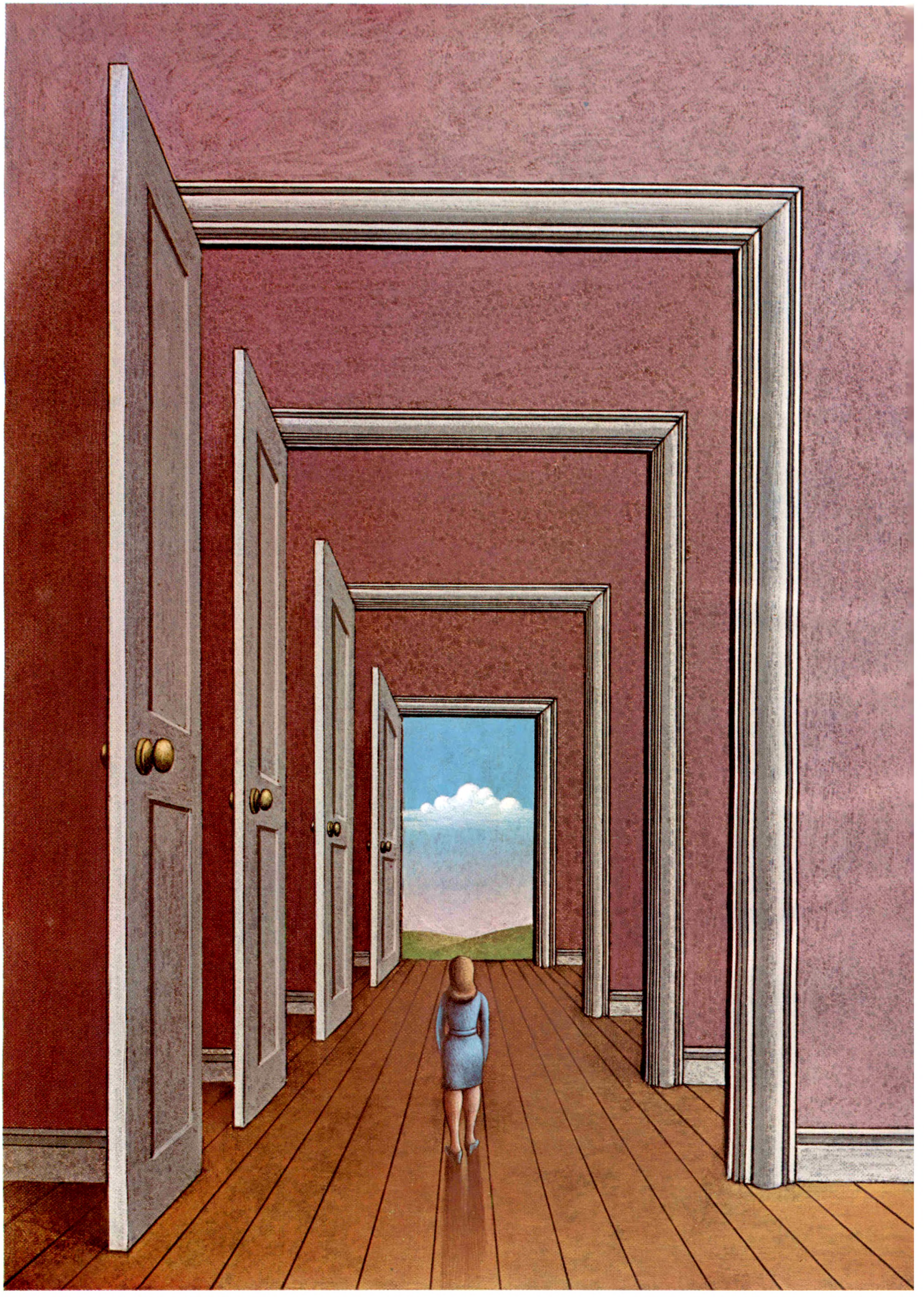
HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

Alcoholism/ANTABUSE® (disulfiram)

Ayerst®

AYERST LABORATORIES
New York, N.Y. 10017

7343



A HEAD START FOR THE CLINICALLY DEPRESSED PATIENT.

All tricyclic antidepressants take from one to four weeks before optimal antidepressant effect is seen.

Sinequan (doxepin HCl)—the newest tricyclic antidepressant—is no exception.

But, in that waiting period, Sinequan offers the clinically depressed patient both:

prompt sedative activity to begin relieving the sleep disturbances often characteristic of depression, and

marked antianxiety activity to help relieve the apprehension, tension, worry and fear that usually accompany depression.

Further, the incidence of cardiovascular side effects with Sinequan is relatively low. Tachycardia and hypotension are infrequent. (Drowsiness is the most common side effect.) And Sinequan, unlike other tricyclic antidepressants, does not generally affect the activity of guanethidine and similarly acting compounds at usual clinical doses.

Prompt sedative activity. Marked antianxiety activity. Low incidence of cardiovascular side effects.

It's a head start for the clinically depressed patient.

THE NEWEST TRICYCLIC ANTIDEPRESSANT— WITH DIFFERENCES YOU CAN SEE.

Sinequan®
DOXEPIN HCl
25-mg. and 50-mg. capsules

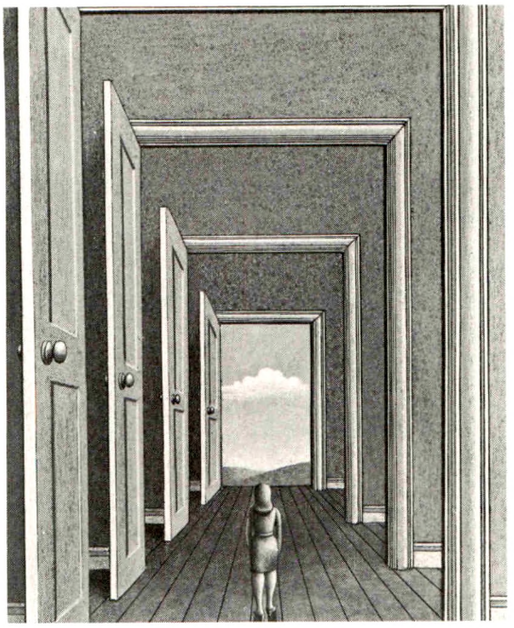
Pfizer **LABORATORIES DIVISION**
PFIZER INC.

(See Brief Summary on following page for information on adverse reactions, contraindications, warnings and precautions.)

©1973, PFIZER INC.

Sinequan®
DOXEPIN HCl
25-mg. and 50-mg. capsules

THE NEWEST TRICYCLIC ANTIDEPRESSANT–WITH DIFFERENCES YOU CAN SEE.



BRIEF SUMMARY
Sinequan® (doxepin HCl) **Capsules**
Contraindications. Sinequan (doxepin HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100 and 1000.

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
PFIZER INC.

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models— **PORTABLE FOR OFFICE AND CLINIC**



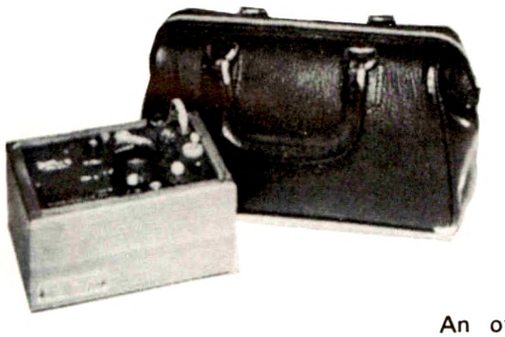
The Reiter MODEL SOS—THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives—patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes —a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



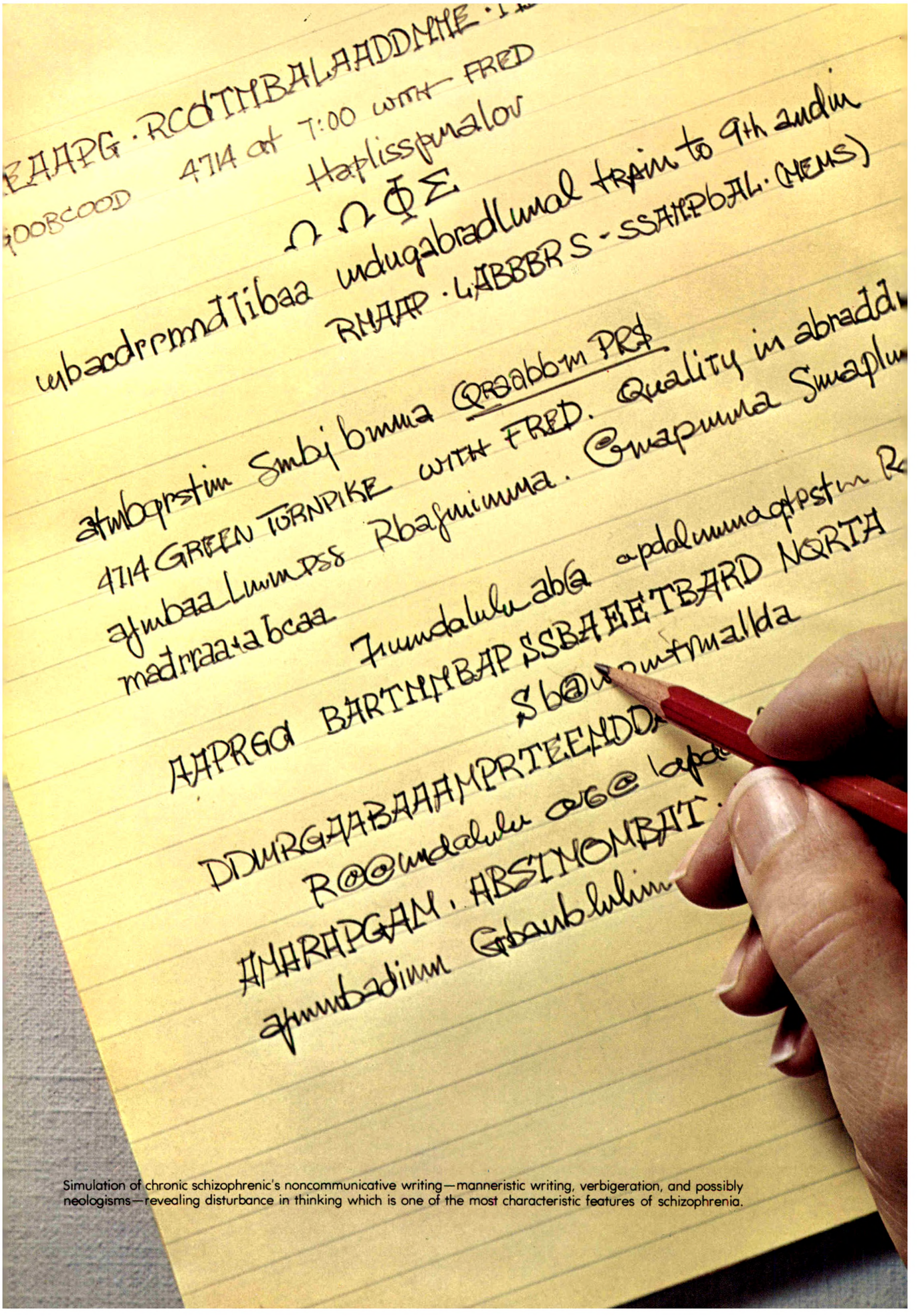
The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

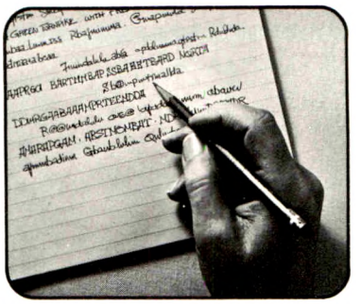
For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211



Simulation of chronic schizophrenic's noncommunicative writing—manneristic writing, verbigeration, and possibly neologisms—revealing disturbance in thinking which is one of the most characteristic features of schizophrenia.

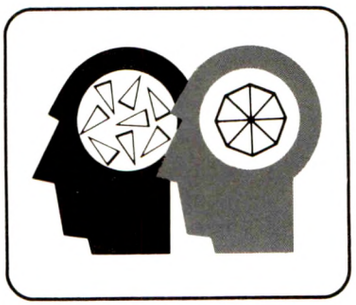

Jnusual thought content...
a target symptom
in schizophrenia
that responds
particularly well
to treatment
with SERENTIL®
(mesoridazine)
Tablets, 50 mg. (as the besylate)
The disturbances in thinking and conceptualization that are most characteristic of schizophrenia are particularly responsive to treatment with Serentil. Symptoms of unusual thought content, conceptual disorganization, and hallucinatory behavior—whatever their degree of severity—are potentially reversible.
Serentil is effective in both acute and chronic forms of schizophrenia. Serentil Tablets and Concentrate provide dosage flexibility for initiating and maintaining therapy for both hospitalized and discharged patients.
The injectable form of Serentil is especially valuable for efficient management of symptoms in many newly admitted patients and for rapid control of acute episodes in office practice.
For brief summary, please see following page.
SANDOZ
73-731



Unusual thought content...

a target symptom in schizophrenia that responds particularly well to treatment with

SERENTIL®
(mesoridazine)
Tablets, 50 mg. (as the besylate)



Contraindications: Severe central nervous system depression; comatose states from any cause; hypersensitivity.

Warnings: Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

Usage in Pregnancy: Safe use in pregnancy has not been established; administer only when the potential benefits exceed the possible risks to mother and fetus.

Usage in Children: Not recommended in children under 12 years.

Precautions: Although ocular changes to date have not been related to mesoridazine, such changes have been seen with other drugs of this class. Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection. Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy; a single case of transient granulocytopenia has been associated with Serentil. Since convulsive seizures have been reported, patients receiving anticonvulsant medication should be maintained on that regimen while receiving Serentil.

Adverse Reactions: Drowsiness and hypotension are the most prevalent side effects encountered. Side effects tend to reach their maximum level of severity early with the exception of a few (rigidity and motoric effects) which occur later in therapy. With the exceptions of tremor and rigidity, adverse reactions were generally found among patients who received relatively high doses early in treatment.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos). *Autonomic Nervous System:* Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision. *Genitourinary System:* Inhibition of ejaculation, impotence, enuresis, incontinence. *Skin:* Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema. *Cardiovascular System:* Hypotension and tachycardia; EKG changes (see *Cardiovascular Effects* below).

The following have occurred with phenothiazines and should be considered: *Autonomic Reactions:* Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions:* Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias:* Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions:* Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity:* Jaundice, biliary stasis. *Cardiovascular Effects:* Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a U wave have been observed with phenothiazines, including Serentil (mesoridazine); these appear to be reversible and due to altered re arization, not myocardial damage. While the no evidence of a causal relationship bet these changes and significant disturbanc cardiac rhythm, sudden and unexpected de apparently due to cardiac arrest have occu in patients showing characteristic electroca graphic changes while taking the drug. V proposed, periodic electrocardiograms are regarded as predictive. Hypotension, rarel sulting in cardiac arrest. *Extrapyramidal S toms:* Akathisia, agitation, motor restless dystonic reactions, trismus, torticollis, opi tonus, oculogyric crises, tremor, muscular rig akinesia. *Persistent Tardive Dyskinesia:* Persi and sometimes irreversible tardive dyskin characterized by rhythmical involuntary m ments of the tongue, face, mouth, or jaw (protrusion of tongue, puffing of cheeks, pu ing of mouth, chewing movements) and s times of extremities may occur on long- therapy or after discontinuation of therapy, the risk being great elderly patients on high-dose therapy, especially females; if symptom pear, discontinue all antipsychotic agents. Syndrome may be mask treatment is reinstituted, dosage is increased, or antipsychotic a is switched. Fine vermicular movements of tongue may be an e sign, and syndrome may not develop if medication is stopped at time. *Endocrine Disturbances:* Menstrual irregularities, altered lib gynecomastia, lactation, weight gain, edema, false positive p nancy tests. *Urinary Disturbances:* Retention, incontinence. Ot Hyperpyrexia; behavioral effects suggestive of a paradoxical reac including excitement, bizarre dreams, aggravation of psychoses, toxic confusional states; following long-term treatment, a pec skin-eye syndrome marked by progressive pigmentation of ski conjunctiva and/or accompanied by discoloration of exposed s and cornea; stellate or irregular opacities of anterior lens and cor

How Supplied: *Tablets:* 10 mg., 25 mg., 50 mg., and 100 mesoridazine (as the besylate). Packages of 100 and 5000.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besylate)]. Ina ingredients—Disodium Edetate, U.S.P., 0.5 mg.; Sodium Chlo U.S.P., 7.2 mg.; Carbon Dioxide Gas (Bone Dry) q.s., Water fo jection, U.S.P., q.s. to 1 cc. Boxes of 20 and 100.

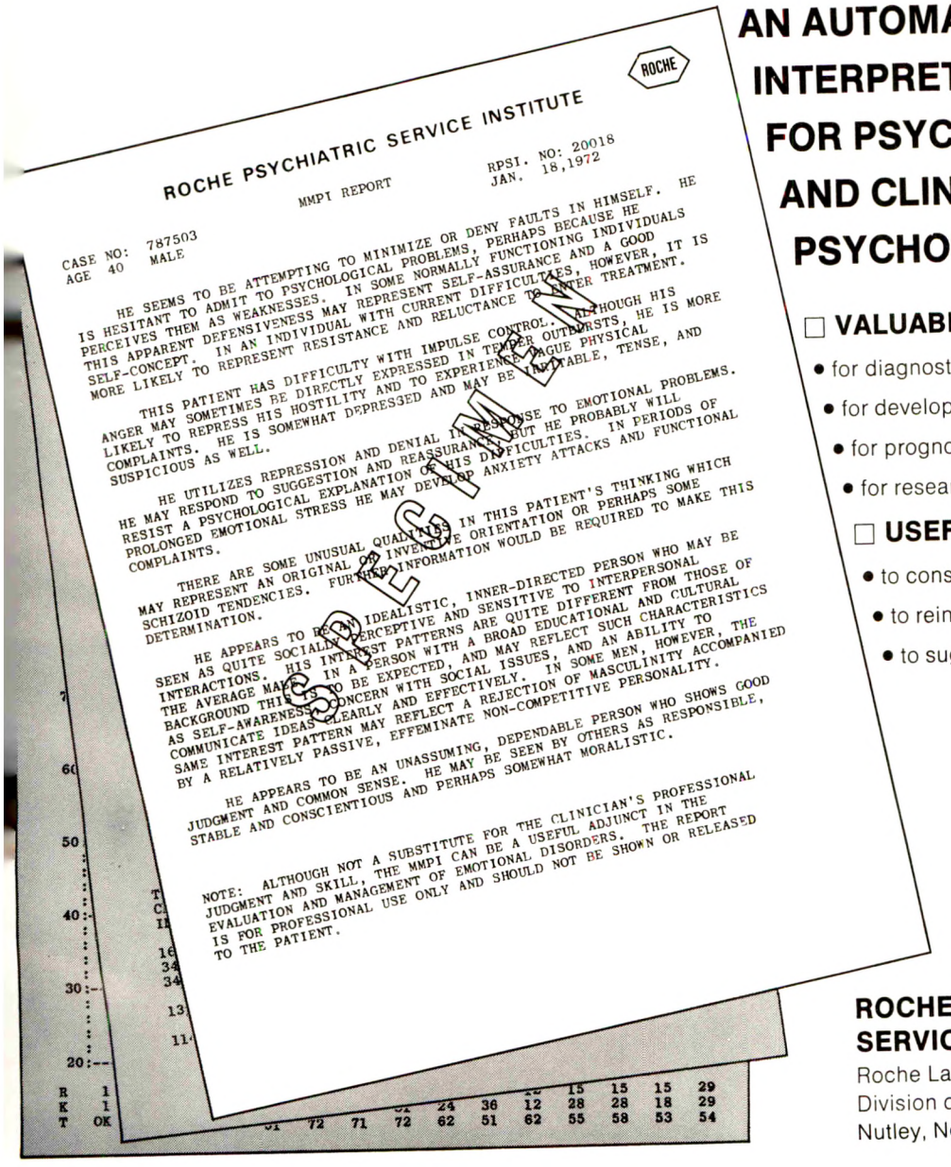
Concentrate: contains 25 mg. mesoridazine (as the besylate) pe Immediate containers: Amber glass bottles of 4 fl. oz. (118 packaged in cartons of 12 bottles, with an accompanying dro graduated to deliver 10 mg., 25 mg., and 50 mg. of mesorido (as the besylate). Store below 77° F; protect from light; disp in amber glass bottles only. May be diluted with distilled w acidified tap water, orange juice or grape juice just prior to adr tration; preparation and storage of bulk dilutions is not recommer

Before prescribing or administering, see package insert or PDR.

73-731R

SANDOZ PHAMACEUTICALS, EAST HANOVER, N.J. 07936

Minnesota Multiphasic Personality Inventory



ROCHE PSYCHIATRIC SERVICE INSTITUTE

MMPI REPORT

RPSI. NO: 20018
JAN. 18,1972

CASE NO: 787503
AGE 40 MALE

HE SEEMS TO BE ATTEMPTING TO MINIMIZE OR DENY FAULTS IN HIMSELF. HE IS HESITANT TO ADMIT TO PSYCHOLOGICAL PROBLEMS, PERHAPS BECAUSE HE PERCEIVES THEM AS WEAKNESSES. IN SOME NORMALLY FUNCTIONING INDIVIDUALS THIS APPARENT DEFENSIVENESS MAY REPRESENT SELF-ASSURANCE AND A GOOD SELF-CONCEPT. IN AN INDIVIDUAL WITH CURRENT DIFFICULTIES, HOWEVER, IT IS MORE LIKELY TO REPRESENT RESISTANCE AND RELUCTANCE TO ENTER TREATMENT.

THIS PATIENT HAS DIFFICULTY WITH IMPULSE CONTROL. ALTHOUGH HIS ANGER MAY SOMETIMES BE DIRECTLY EXPRESSED IN TEMPER OUTBURSTS, HE IS MORE LIKELY TO REPRESS HIS HOSTILITY AND TO EXPERIENCE VAGUE PHYSICAL COMPLAINTS. HE IS SOMEWHAT DEPRESSED AND MAY BE IRRITABLE, TENSE, AND SUSPICIOUS AS WELL.

HE UTILIZES REPRESSION AND DENIAL IN RESPONSE TO EMOTIONAL PROBLEMS. HE MAY RESPOND TO SUGGESTION AND REASSURANCE, BUT HE PROBABLY WILL RESIST A PSYCHOLOGICAL EXPLANATION OF HIS DIFFICULTIES. IN PERIODS OF PROLONGED EMOTIONAL STRESS HE MAY DEVELOP ANXIETY ATTACKS AND FUNCTIONAL COMPLAINTS.

THERE ARE SOME UNUSUAL QUALITIES IN THIS PATIENT'S THINKING WHICH MAY REPRESENT AN ORIGINAL OR INVENTIVE ORIENTATION OR PERHAPS SOME SCHIZOID TENDENCIES. FURTHER INFORMATION WOULD BE REQUIRED TO MAKE THIS DETERMINATION.

HE APPEARS TO BE AN IDEALISTIC, INNER-DIRECTED PERSON WHO MAY BE SEEN AS QUITE SOCIALLY PERCEPTIVE AND SENSITIVE TO INTERPERSONAL INTERACTIONS. HIS INTEREST PATTERNS ARE QUITE DIFFERENT FROM THOSE OF THE AVERAGE MALE. IN A PERSON WITH A BROAD EDUCATIONAL AND CULTURAL BACKGROUND THIS IS TO BE EXPECTED, AND MAY REFLECT SUCH CHARACTERISTICS AS SELF-AWARENESS, CONCERN WITH SOCIAL ISSUES, AND AN ABILITY TO COMMUNICATE IDEAS CLEARLY AND EFFECTIVELY. IN SOME MEN, HOWEVER, THE SAME INTEREST PATTERN MAY REFLECT A REJECTION OF MASCULINITY ACCOMPANIED BY A RELATIVELY PASSIVE, EFFEMINATE NON-COMPETITIVE PERSONALITY.

HE APPEARS TO BE AN UNASSUMING, DEPENDABLE PERSON WHO SHOWS GOOD JUDGMENT AND COMMON SENSE. HE MAY BE SEEN BY OTHERS AS RESPONSIBLE, STABLE AND CONSCIENTIOUS AND PERHAPS SOMEWHAT MORALISTIC.

NOTE: ALTHOUGH NOT A SUBSTITUTE FOR THE CLINICIAN'S PROFESSIONAL JUDGMENT AND SKILL, THE MMPI CAN BE A USEFUL ADJUNCT IN THE EVALUATION AND MANAGEMENT OF EMOTIONAL DISORDERS. THE REPORT IS FOR PROFESSIONAL USE ONLY AND SHOULD NOT BE SHOWN OR RELEASED TO THE PATIENT.

SPECIMEN

AN AUTOMATED INTERPRETATION SERVICE FOR PSYCHIATRISTS AND CLINICAL PSYCHOLOGISTS

☐ **VALUABLE CLINICAL TOOL**

- for diagnostic information
- for development of treatment programs
- for prognostic implications
- for research

☐ **USEFUL CLINICAL ADJUNCT**

- to conserve professional time
- to reinforce diagnostic impressions
- to suggest areas for further exploration

ROCHE

ROCHE PSYCHIATRIC SERVICE INSTITUTE
Roche Laboratories, Dept. A
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The challenge: versatility

The stereotype image of "psychiatrist and couch" is a anachronism because today's psychiatrist is called on to diag nose and treat depression in a variety of clinical settings. An when an antidepressant medication is chosen, it must be as flexible and as adaptable as the physician prescribing it.



The psychiatrist's office still represen the setting in which the psychoanalyt process recognizes its fullest potentia Frequently, however, an antidepressan must be employed to foster a working the apeutic relationship. With effective symp tomatic relief often provided by ELAVI (Amitriptyline HCl, MSD), depressed pa tients may be able to concentrate on underlying factors instea of somatic manifestations.

The general hospital today usually provides a psychiatri unit where depressed patients are treated. Here, too, th symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



n the outpatient clinic, where follow-p treatment may be necessary for three nonths or longer, ELAVIL is highly ef-ective in maintaining relief, especially n patients who responded well to higher oses while hospitalized. As a result, nese patients may continue to function n their daily activities.



n the mental hospital, severely depressed patients present hallenges for psychiatrist and staff alike. Here, the useful-ess of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



The community mental health center, a remarkable innovation in the field of modern psychiatry, offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

in the treatment of depression

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

helps open many doors

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

addendum

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for most outpatients, who generally do well on 25 mg three times a day. This dosage may be increased to a total of 150 mg a day. Dosage increases are made preferably in the late afternoon or at bedtime. The sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be indicated whenever higher dosages are required, as for example when increases are necessary in the late afternoon or bedtime doses. It may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher dosages.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.
When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics,close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

in the treatment of clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)
helps open many doors



Suspicious and hostile?...Or accessible?

While psychotic symptoms remain acute, the barrier between you and the overly suspicious, hostile patient may be insurmountable. Prompt intervention with HALDOL (haloperidol) often makes it possible for you to reach... relate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

accessibility often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

© McNeil Laboratories, Inc., 1973

Haldol®
(HALOPERIDOL)
a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate
for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: HALDOL (haloperidol) is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 6/73

McNEIL McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

rom USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows...maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

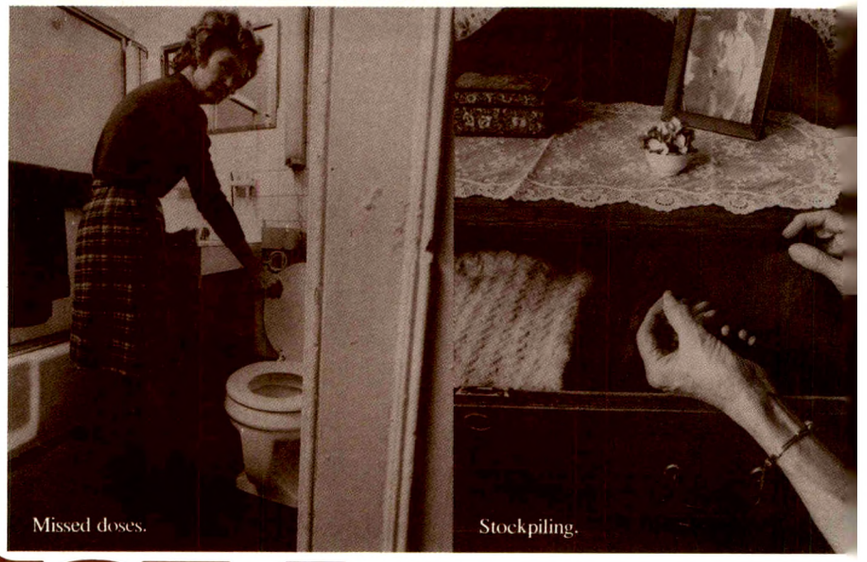
USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS

FOUR REASONS FOR READMISSION...



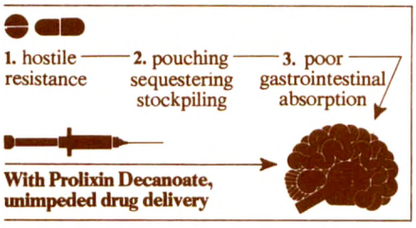
For schizophrenic patients...

A way out

that helps them stay out

Controlled Drug Delivery with
PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)
Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer, with an average duration of effect of about 2 weeks

Controlled drug delivery helps prevent disruption of therapy—one of the commonest causes of psychotic relapse. For the inpatient it means unimpeded drug delivery with improved chances of discharge.



For the outpatient it means improve chances for prolonged remission: "...th duration of remission and the incidenc of relapse are directly related to keepin the patient medicated after his return t the community."[1]

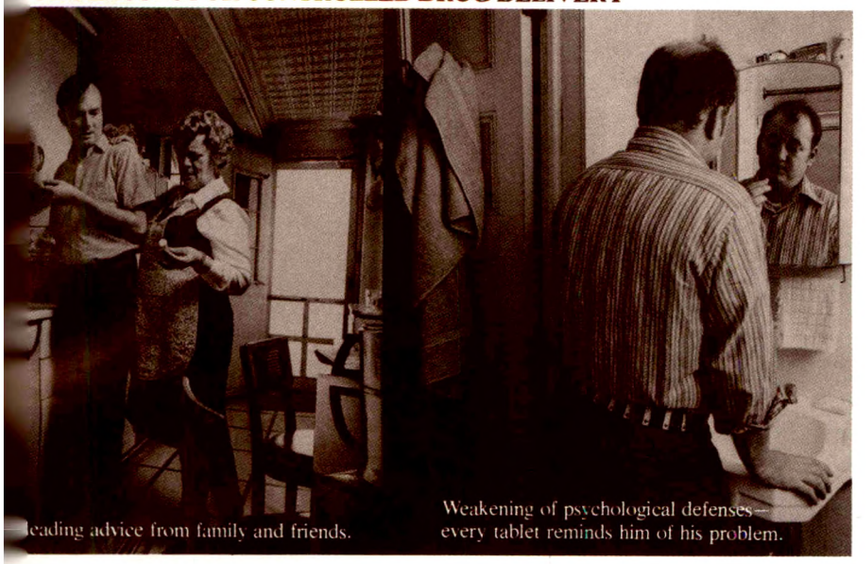
Controlled drug delivery helps the inpatient out

- Keeps the patient medicated...help make him more manageable, more co fortable, and more amenable to tota treatment. With oral medication, on th other hand, approximately one out c every five patients does not take his me ication, even when administered by th nursing staff.[2]
- Eliminates the problem of missed, los or hidden doses. Prevents stockpiling.
- Assures regular medication intake.
- Lightens responsibilities of the hospita staff...simplifies patient management b obviating the need for multiple doses.
- Increases the likelihood of discharge In one study[3] of 24 long-term hospita patients treated with Prolixin Decanoat (Fluphenazine Decanoate Injec tion) every 7 days to 3 weeks:

DISCHARGED	CONSIDERED DISCHARGEABLE	NO IMPROVEMENT
13	4	7

Dischargeability "may also have been en hanced because the staff, the patien and the family were assured of an ac equate and regular medication intake."[3]

OD REASONS FOR CONTROLLED DRUG DELIVERY



leading advice from family and friends.

Weakening of psychological defenses—every tablet reminds him of his problem.

ntrolled drug delivery helps keep outpatient out

lelps assure continuity of medication makes prolonged remission more ely. With oral medication, on the er hand, "approximately 50% of all charged psychotic patients fail to take en the first dose of their outpatient dication."[2]

Enhances chances for rehabilitation... omotes acceptance socially, in the nily, and on the job because of sus- ined control of symptomatology.

Eases family adjustment by eliminating ncern about "taking his medicine."

Avoids the potential dangers of stock- ing, particularly for the suicidal.

Once administered, therapy cannot be ered by the patient, by his family, or anyone else.

The unique advantages of controlled ug delivery apply equally to the pa- nt who has never been hospitalized. They are advantages that can help make custodial care unnecessary as long as treatment continues.

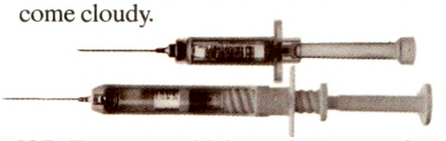
Controlled drug delivery saves time, reduces cost in the hospital, clinic, office

Saves time in the hospital:

18 PATIENTS	18 PATIENTS
	
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Saves time in the clinic and in the office: Most patients report for their injections only once in every two-week period.

Prolixin Decanoate (Fluphenazine Decanoate Injection) also offers the convenience of easy-to-use Unimatic® Syringes: Unimatic single-dose preassembled syringes and Unimatic cartridge-needle units with a reusable plastic holder. Vials of 5 cc. Prolixin Decanoate are available for use with dry syringes and needles (at least 21 gauge). Use of a wet needle may cause the solution to become cloudy.



N.B. Extrapyramidal reactions occur frequently. Most often they are reversible and can usually be controlled by administration of antiparkinsonian drugs. However, in some instances, they are persistent—particularly in the case of tardive dyskinesia (see Adverse Reactions section of Brief Summary). Patients should be forewarned and reassured.

References: 1. Kinross-Wright, V. J.: Cited in Med. Tribune, Sept. 13, 1965, pp. 1, 27. 2. Goldberg, H. L., DiMascio, A. and Chaudhary, B.: Psychosomatics 11:173, May-June 1970. 3. Keskiner, A. et al.: Arch. Gen. Psychiatry 18:477, Apr. 1968. 4. Platt, R.: Br. J. Social Psychiatry 2:187, 1968.

Controlled Drug Delivery *with* PROLIXIN® DECANOATE FLUPHENAZINE DECANOATE INJECTION)

For product Brief Summary, see following page.

SQUIBB HOSPITAL DIVISION

Controlled Drug Delivery
in schizophrenia with
PROLIXIN® DECANOATE
(FLUPHENAZINE DECANOATE INJECTION

BRIEF SUMMARY
Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy. Safety and efficacy in children have not been established because of inadequate experience in use in children.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anticholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of antiparkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 cc. Unimatic® single dose preassembled syringes and cartridge-needle units, and 5 cc. vials.



SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H423-023
Princeton, N. J. 08540

RECENT ADVANCES IN THE BIOLOGY OF SCHIZOPHRENIA *by* **Thomas A. Ban,** *McGill Univ., Montreal, Quebec, Canada.* New information on the biology of schizophrenia is presented here in a systematic and comprehensive manner. Neuroleptics have brought about fundamental changes in current concepts of schizophrenia that may lead to therapies which are based on theoretical principles. Students, practitioners and researchers in psychiatry will find the integration of these new informations in this monograph of great importance. *'73, 132pp., 6 il., 28 tables, $12.50*

BOOKS BOUND FOR YOUR SHELF

THE MALPRACTICE OF PSYCHIATRISTS: Malpractice in Psychoanalysis, Psychotherapy and Psychiatry *by* **Donald J. Dawidoff,** *New York City.* The author describes where possible areas of malpractice by psychiatrists and examines both the nature of and remedy for malpractice in the verbal therapies of psychoanalysis and psychotherapy. The specialized legal theories of breach of fiduciary duty, undue influence and words negligently spoken are applied to psychotherapy and psychoanalysis. *'73, 184 pp., $9.75*

CLINICAL USE OF PSYCHOTHERAPEUTIC DRUGS *by* **Leo E. Hollister,** *Stanford Univ. School of Medicine, Palo Alto, California.* Written for practicing physicians, psychiatrists and students who wish to learn how to better use drugs in the treatment of patients with emotional disorders. The book covers drug use in treating emotional disorders. Each class of drugs is considered in relation to the chemical and pharmacological differences among its members. *'73, 192 pp., 11 il., 13 tables, $6.95 cloth, $2.25 paper*

CRISIS INTERVENTION AND COUNSELING BY TELEPHONE *edited by* **David Lester,** *Stockton State College, Pomona, New Jersey, and* **Gene W. Brockopp,** *Suicide Prevention and Crisis Service, Buffalo, New York (23 Contributors)* Differentiation of telephone counseling, and its unique features, from other modes of counseling and proposed ways in which they can be handled are discussed. The selection and training of those who perform the counseling over the telephone, including the controversial development and increasing use of paraprofessionals is thoroughly analyzed. *'73, 336 pp., 6 il., 15 tables, $11.95*

SELF-DISCOVERY THROUGH SELF-EXPRESSION: Use of Art in Psychotherapy With Children and Adolescents *by* **Mala Betensky.** '73, 384 pp., 222 il. (32 in full color), $13.95

MAN FOR MAN: A Multidisciplinary Workshop on Affecting Man's Social and Psychological Nature Through Community Action *edited by* **John L. Carleton,** *Santa Barbara Psychiatric Medical Group, and* **Ursula Mahlendorf,** *Univ. of California, Santa Barbara. (18 Contributors)* '73, 384 pp., $10.95

PSYCHOSURGERY: Proceedings of the Second International Conference on Psychosurgery. *Held in Copenhagen, Denmark. Edited by* **Edward Hitchcock,** *The Royal Infirmary, Edinburgh, Scotland;* **Lauri V. Laitinen,** *Univ. Central Hospital, Helsinki, Finland; and* **Kjeld Vaernet,** *Rigshospitalet, Copenhagen, Denmark. Introduction by* **William Beecher Scoville.** *(79 Contributors)* '72, 456 pp., 120 il., 56 tables, $24.75

LAW, PSYCHIATRY AND THE MENTALLY DISORDERED OFFENDER. Volume I *edited by* **Lynn M. Irvine, Jr.,** *Illinois Security Hospital, Chester, Illinois, and* **Terry B. Brelje,** *Department of Corrections, Menard, Illinois. (11 Contributors)* '72, 164 pp., 1 table, $9.75

LAW, PSYCHIATRY AND THE MENTALLY DISORDERED OFFENDER. Volume II *edited by* **Lynn M. Irvine, Jr.,** *Illinois Security Hospital, Chester, Illinois, and* **Terry B. Brelje,** *Department of Corrections, Menard, Illinois. (12 Contributors)* '73, 148 pp., $9.75

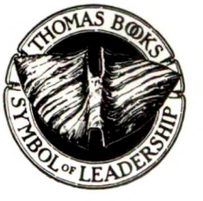
BRAIN UNIT ACTIVITY DURING BEHAVIOR *edited by* **M. Ian Phillips,** *Univ. of Iowa College of Medicine. (26 Contributors)* '73, 376 pp., 190 il., 7 tables, $15.75

BEHAVIOR THERAPY WITH DELINQUENTS *compiled and edited by* **Jerome S. Stumphauzer,** *Univ. of Southern California School of Medicine, Los Angeles. (33 Contributors)* '73, 376 pp., 42 il., 10 tables, $11.95

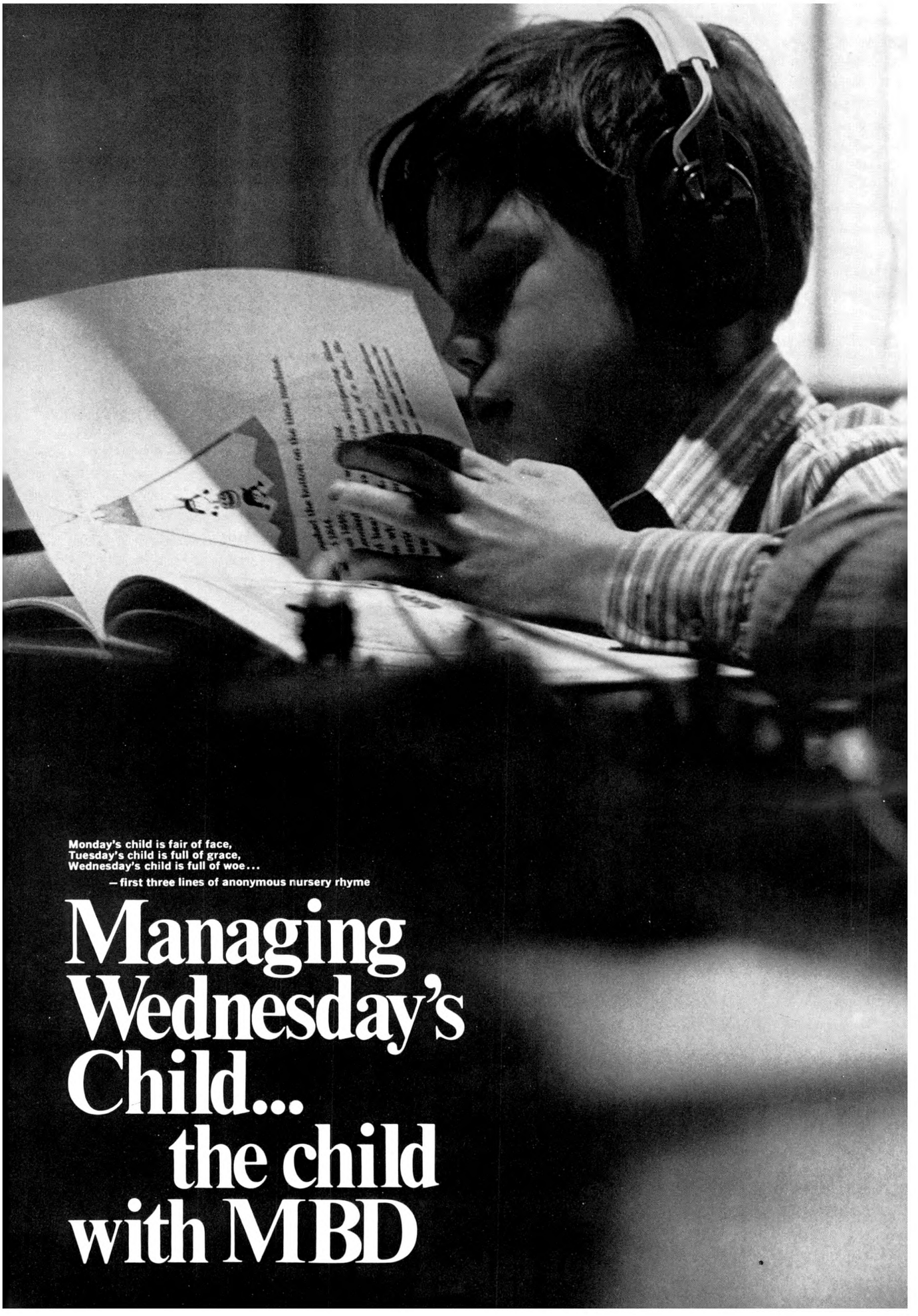
THE LSD CONTROVERSY: An Overview *by* **Maurice S. Tarshis,** *Formerly, Alcohol and Drug Section, Mental Health Division, State of Oregon. Foreword by* **Herman A. Dickel.** '72, 96 pp., 1 il., 2 tables $6.50

UNDERSTANDING THROUGH COMMUNICATIONS: Structured Experiments in Self-Exploration *by* **Lois Timmins,** *Timberlawn Psychiatric Hospital, Dallas, Texas. Foreword by* **Howard M. Burkett.** '72, 336 pp., $11.75

Complete list of books in this field sent free on request



Charles C Thomas • Publisher 301-327 East Lawrence Avenue **Springfield • Illinois • U.S.A.**



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD —Minimal Brain Dysfunction—can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference

1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

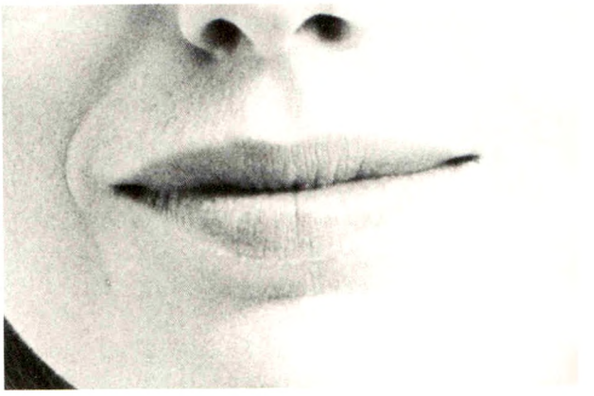
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

Ritalin®
(methylphenidate)
only when medication is indicated

CIBA

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

ntraindications: Known hypersensitivity; acute recovery phase following myocardial arction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe nvulsions, and deaths have occurred in patients receiving tricyclic antidepressant and AOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, minimum of 14 days should be allowed to elapse after the latter is discontinued. Protyline HCl should then be initiated cautiously with gradual increase in dosage until timum response is achieved.

rnings: May block the antihypertensive effect of guanethidine or similarly acting compunds. May impair mental and/or physical abilities required for the performance of hazards tasks, such as operating machinery or driving a motor vehicle. Should be used with ution in patients with a history of seizures and, because of its autonomic activity, in tients with a tendency to urinary retention or increased intraocular tension.

chycardia and postural hypotension may occur more frequently than with other antipressant drugs. Should be used with caution in elderly patients and patients with cardioscular disorders; such patients should be observed closely because of the tendency of e drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conction time. Myocardial infarction and stroke have occurred with drugs of this class. n rare occasions, hyperthyroid patients or those receiving thyroid medication ay develop arrhythmias when this drug is given.

age in Children: Not recommended for use in children because safety and effectiveness the pediatric age group have not been established.

age in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, se in pregnant women, nursing mothers, or women who may become pregnant requires at possible benefits be weighed against possible hazards to mother and child.

ecautions: When protriptyline HCl is used to treat the depressive component of schizorenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, epressed patients may experience a shift toward the manic phase; paranoid delusions, th or without associated hostility, may be exaggerated. In any of these circumstances, it ay be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug oncurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive agitated patients.

hen given with anticholinergic agents or sympathomimetic drugs, including epinephrine ombined with local anesthetics, close supervision and careful adjustment of dosages are equired. May enhance response to alcohol and effects of barbiturates and other CNS epressants. Possibility of suicide in depressed patients remains during treatment and ntil significant remission occurs; this type of patient should not have easy access to arge quantities of the drug. Concurrent administration with electroshock therapy may ncrease hazards of therapy; such treatment should be limited to patients for whom it is ssential. Discontinue drug several days before elective surgery, if possible. Both elevation nd lowering of blood sugar levels have been reported.

dverse Reactions: *Note:* Included in this listing are a few adverse reactions which have ot been reported with this specific drug. However, the pharmacologic similarities among he tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation nd anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning in humans. Animal studies have shown that physostigmine also reverses certain toxic effects of protriptyline, but to a lesser extent.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

The balanced approach in adjunctive drug therapy



Especially relevant in psychiatric practice

Relief of obstructive anxiety through adjunctive drug therapy is often the means by which psychotherapeutic progress may resume. It is generally agreed, however, that for optimal benefit such anxiety should not be succeeded by a state of oversedation, with resultant flattening of emotional response.

For this reason, the benzodiazepines are widely preferred for reduction of excessive anxiety in psychoneurotic patients. They are considered among the safer, better-tolerated, less sedative of the effective antianxiety agents. In most cases, Librium (chlordiazepoxide HCl)—the first clinically applied benzodiazepine—provides the well-balanced effect frequently needed in treatment of overanxious office patients.

Librium (chlordiazepoxide HCl) dosage meets patient needs

The dosage schedule should have as its goal the relief of inappropriate anxiety. When that

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of

Antianxiety effect without loss of affect



has been accomplished, Librium (chlordiazepoxide HCl) therapy should be reduced, then discontinued. Experience has shown that, in proper dosage, Librium seldom impairs mental acuity, a particular advantage for ambulatory patients who must continue to perform daily activities. (See Warnings section below.) As with all CNS-acting agents, however, patients receiving Librium should be cautioned against activities requiring complete mental alertness.

In most instances, Librium (chlordiazepoxide HCl) promptly reduces inappropriate anxiety to levels necessary for normal performance. Thereby it helps expedite the psychotherapeutic process by freeing the patient to retrieve the repressed material which must be explored if he is to resolve his emotional conflicts.

In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of product information below.)

for control of inappropriate anxiety

Librium®
(chlordiazepoxide HCl)

10-mg, 25-mg capsules t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

A new publication from
THE JOINT INFORMATION SERVICE
of the American Psychiatric Association
and the National Association for Mental Health

MENTAL HEALTH ON THE CAMPUS

By Raymond M. Glasscote
Michael E. Fishman
Clifford B. Reifler
James Raybin
Floyd D. Turner
Bernard L. Bloom
Samuel Pearlman
E. Robert Sinnett

". . . A most significant, objective explication of campus mental health. I endorse it wholeheartedly."
—Dana Farnsworth

In the hope of stimulating interest in creating support services for students experiencing any form of emotional or behavioral crisis, the Joint Information Service undertook to survey the numerous helping resources being provided at a selected group of colleges of widely varying characteristics. To do so it enlisted the talents of several of the most distinguished and accomplished practitioners in university mental health services. After extensive investigation, six schools outstanding for their mental health networks, plus a unique facility that contracts psychiatric treatment and consultation to more than a score of schools, were chosen for intensive study. Each program was visited by the authors, who interviewed not only the staff of the formal mental health services but representatives of the administration, housing, religious and many other kinds of activities and programs, faculty members, student leaders, and students who had utilized the mental health services. Consistently the interviews revealed some startling changes in campus interests and values during the year or two preceding the visits. In response to student demands, most of the schools had added seminars and lectures on marriage preparation and sexuality, with the result, at one school, of an almost ninety percent reduction in unplanned pregnancies. There was various tentative evidence that on the one hand drug usage, overall, had passed its peak, but on the other that marijuana use had been considerably incorporated into the social fabric of most of the schools.

The volume describes many specific services which support and enhance the emotional well-being of students. There are also detailed descriptions of the formal mental health services, including various approaches to individual and group treatment, medication, and provisions for hospitalization.

These and many other aspects of the emotional life of the campus are discussed in this volume, both in an overview of the contemporary college scene in America, and in detailed individual descriptions of the schools with their impressive range of supporting services.

216 pp. casebound $7.00

Send Coupon to:

American Psychiatric Association
Publications Sales
1700 Eighteenth St., N.W.
Washington, D.C. 20009

Please send me _____ copy(ies) of **Mental Health on the Campus**, Order #202, @ $7.00 ea. (four or more copies, $6.00 ea., eight or more copies, $5.00 ea.)

☐ Bill Me ☐ Check Enclosed

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

973AJP

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator



THE AMERICAN JOURNAL OF PSYCHIATRY

NOW, your journals can become an attractive permanent part of your professional library. These famous Jesse Jones volume files, especially designed to keep your copies orderly, readily accessible for future reference—guard against soiling, tearing, wear or misplacement of copies. These durable files will support 150 lbs. Looks and feels like leather and is washable. The 23-carat gold lettering makes it a fit companion for the most costly binding.

Reasonably priced, too. Only $4.25, 3 for $12.00, 6 for $22.00 POSTPAID U. S. A. ORDERS ONLY. Satisfaction unconditionally guaranteed or your money back.

JESSE JONES BOX CORP. (Since 1843)
Department JP9—Philadelphia 41, Pa. 19141

1974 APA Appointment Books Desk and Pocket-sized

The "week-at-a-glance" Desk Appointment Book and the Pocket-sized version, published by the American Psychiatric Association, provide a quick and organized reference to your weekly engagements. As an added feature, it contains a comprehensive list of organizations and agencies of interest to psychiatrists and mental health professionals—in most cases director's name, address, phone number and date of forthcoming annual meeting are included. Also, there's a section to keep important phone numbers.

The Pocket-sized Appointment Book is 4″ × 7 1/2″, which is small enough to tuck inside your jacket, purse, suitcase or briefcase.

Desk: $5.00 ea.
Pocket: $3.00 ea.
Both: $7.00

Order 10 or more books for your colleagues or as gifts for your friends and take advantage of the 10% discount. Desk: $4.50 ea., Pocket-size: $2.70 ea. (15% discount for 100 or more copies)

Please send me
_____copy(ies) **Desk Appointment Book,** @$5.00 ea. order #141.
_____copy(ies) **Pocket Appointment Book,** @$3.00 ea. order #141-1.
_____set(s) **Desk & Pocket Appointment Book,** @$7.00 a set, order #141-2.
(10% discount for 10-99 copies; 15% discount for 100 or more copies.)

☐ Bill Me ☐ Check Enclosed

(Please Print)

Name _____
Address _____
City _____
State _____ Zip _____

Send Coupon to: Publications Sales
American Psychiatric Association
1700 Eighteenth St. N.W.
Washington, D.C. 20009

973AJP

MOVING?

PLEASE NOTIFY US 6 WEEKS IN ADVANCE

Change of address or name for THE AMERICAN JOURNAL OF PSYCHIATRY and/or PSYCHIATRIC NEWS. Please use only one address for APA mailings. Thank you.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS OR NAME:
(The number of characters indicated include spaces.)

APA IDENTIFICATION NO. (6 characters)

NAME: (24 characters)

(last) (first) (middle initial)

STREET ADDRESS: line #1 (24 characters)

STREET ADDRESS: line #2 (24 characters)

CITY: (16 characters)

STATE: (2 characters)

ZIP: (7 characters)

MAIL TO:

Division of Manpower Research
and Development
AMERICAN PSYCHIATRIC ASSOCIATION
1700 Eighteenth St., N.W.
Washington, D. C. 20009

INDEX TO ADVERTISERS
September 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

AYERST
Antabuse A44–A4

CHARLES C THOMAS • PUBLISHER A6

CIBA PHARMACEUTICAL COMPANY
Ritalin A28–A2
Ritalin MBD A64–A6

DEVEREUX FOUNDATION C

DOW PHARMACEUTICALS
Quide A38–A4

EMPLOYMENT OPPORTUNITIES A7

KNOLL PHARMACEUTICAL
Akineton A3

LAKESIDE LABORATORIES
Norpramin A74–C

LEDERLE
Stresstabs A4

McNEIL LABORATORIES, INC.
Haldol A57–A5

MERCK SHARP & DOHME
Cogentin A12–A13
Elavil A54–A56
Triavil A32–A35
Vivactil A66–A67

PENNWALT CORPORATION
Kolyum, Adapin A17–A20

PFIZER, INC.
Sinequan A46–A48
ROERIG DIVISION
Navane A21–A23

THE PURDUE FREDERICK COMPANY
Senokot A16

REUBEN REITER, ScD. INC.
Electrostimulators A49

ROCHE LABORATORIES
Dalmane A14–A15
Librium A68–A69
MMPI A53
Valium A6–A8

SANDOZ
Mellaril A36
Serentil A50–A52

SANITARIUMS AND PRIVATE HOSPITALS ... A27, A71

SCHERING CORPORATION
Trilafon A9–A11

SMITH KLINE AND FRENCH LABORATORIES
Stelazine A30–A31
Thorazine C2

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A60–A62

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A59
Pertofrane A42–A43

WYETH LABORATORIES
Serax A24–A26

UNUSUAL PRACTICE OPPORTUNITY

Adolf Meyer Center

Decatur, Illinois

Several openings are available with salary ($31,000 plus) and opportunity to join active group.

Boards, academic relationships, and research interests in schizophrenia and psychopharmacology should be the beginning qualifications.

Environment

Recreation

University

Send vita in advance: call collect to

Norris Hansell, M.D.

217-877-3410

PSYCHIATRISTS

Hutchings Psychiatric Center has position available for well-trained, energetic Psychiatrists with clinical teaching and research interests. We are developing a new facility as a major part of a balanced system of service for five counties in Central New York. Our team Psychiatrist leads a 50-man multi-disciplinary team with inpatient, day care, and outpatient facilities. Hutchings Psychiatric Center is adjacent to Upstate Medical Center, and Syracuse University. Affiliated residents in psychiatry and family practice, as well as students in social work, rehabilitation, hospital administration, and psychiatric nursing provide teaching opportunities. A 14-man research staff is available for support of research interests.

Qualifications: Immediate openings are available for board eligible and board certified Psychiatrists. Salary range — $26,485 - $36,445 depending upon qualifications and experience.

Benefits: Vacation, Sick leave, personal leave, health insurance, dental insurance, New York State Retirement System, and major affiliation with S.U.N.Y. College of Medicine at Syracuse.

An Equal Opportunity Employer

Write or Call: Frank B. Soults, M.D., Clinical Director
Hutchings Psychiatric Center
708 Irving Avenue
Syracuse, New York 13210
Phone: (315) 473-4943

psychiatrists

Challenging positions in a progressive community mental health program in a joint New York State and Erie County unified delivery system. All civil service benefits.

Board certified or board eligible psychiatrists only.

INQUIRIES TO: John O. Swearingen

BUFFALO STATE HOSPITAL

400 Forest Avenue

Buffalo, New York 14213

An Equal Opportunity employer

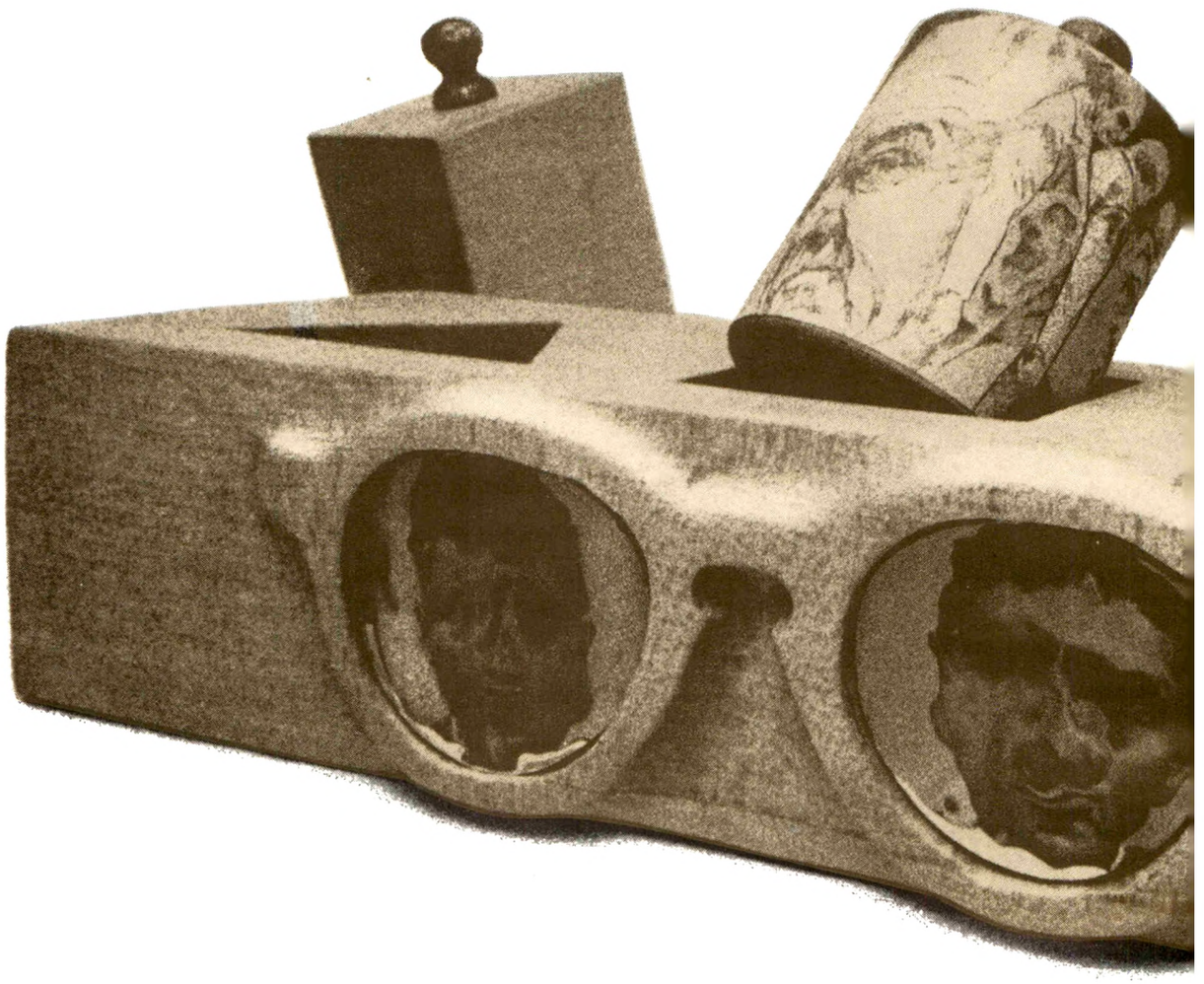
CHILD PSYCHIATRY FELLOWSHIPS

New, Board Approved, Child Psychiatry Fellowships offered in an innovative, established clinical program. Outpatient, Community Child Psychiatry and Residential Treatment offer opportunities for a variety of treatment techniques. Crisis intervention ("life-space" interviews); behavioral therapy, pharmacotherapy; individual, group and family treatment methods; dynamic, social and developmental psychiatry taught. Learning by independent study, seminars, supervised experiences. Administrative experiences and training may be arranged. Multi-disciplinary staff including; six child psychiatrists, pediatrician, pediatric neurologist, psychologist, social workers, special education teachers, speech therapist, occupational therapists, recreational therapists and other consultants.

Program affiliated with the University of Michigan and a variety of clinical settings including; community mental health centers, child guidance clinics, etc. Salaries negotiable. Contact: William E. Kirk, M.D., Director, York Woods Center, Box A2, Ypsilanti, Michigan 48197. Phone: (313) 434-3400.

AN EQUAL OPPORTUNITY EMPLOYER

Help improv your depr cse patients' ability to cope.



In Brief:
Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.
Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.
Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.
Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.
Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosi schizophrenic patients. Close supervision careful adjustment of dosage are required w this drug is given along with anticholinergi sympathomimetic drugs. While taking this d response to alcoholic beverages may be exag ated. There is limited clinical experience in concurrent administration of ECT and ant pressant drugs; thus, one should consider possibility of increased risk relative to bene Discontinue as soon as possible prior to elec surgery because of possible cardiovasc effects. Hypertensive episodes have b observed during surgery in patients on desi mine hydrochloride. Leukocyte and differe counts should be performed in any patient develops fever and sore throat during ther the drug should be discontinued if there is tropenia.
Adverse Reactions: *Cardiovascular:* hypo sion, hypertension, tachycardia, palpitat arrhythmias, heart block, myocardial infarct stroke. *Psychiatric:* confusional states (espec



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

n the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

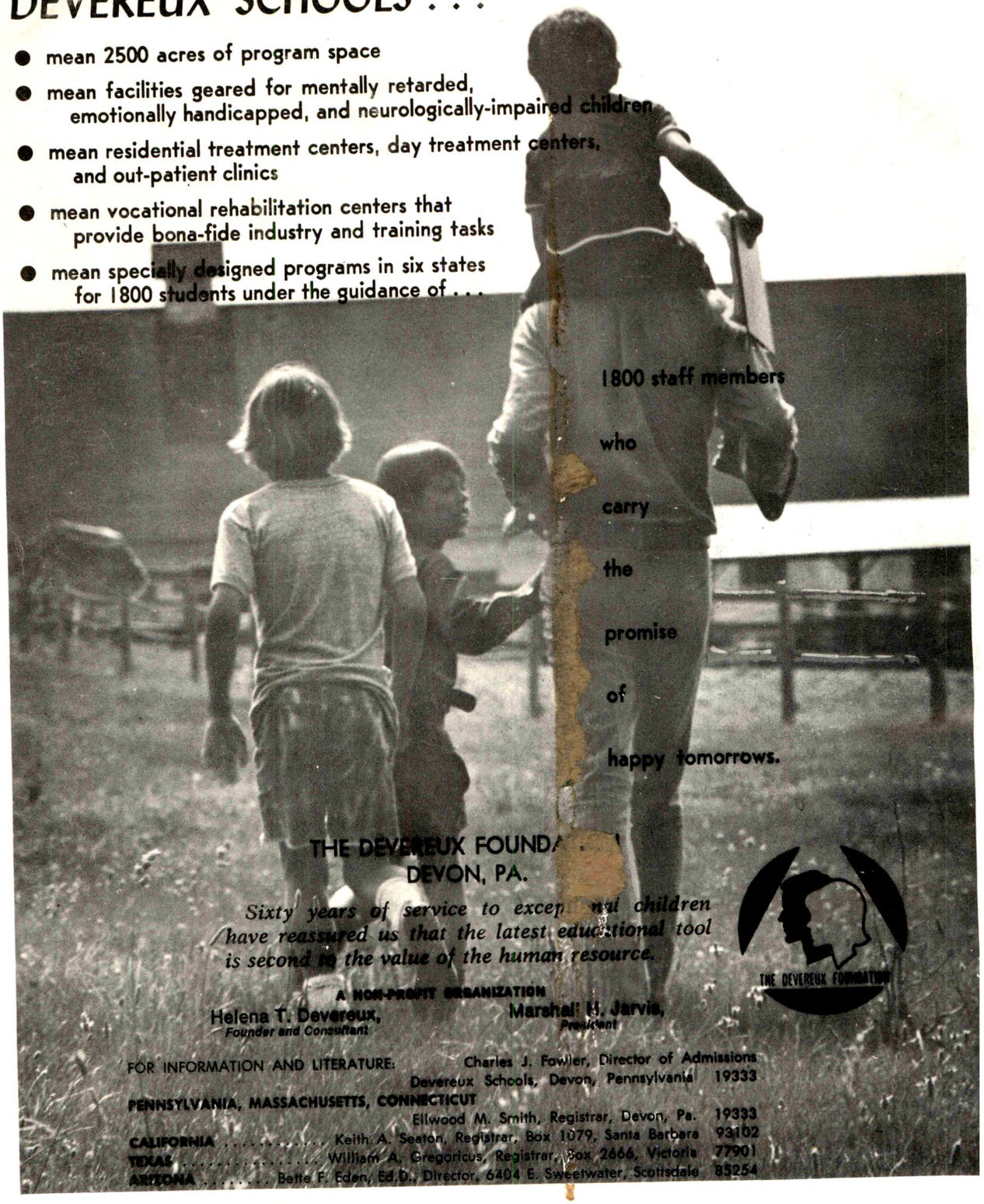
How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.*, sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.*, sugar coated tablets, light green, in bottles of 50, 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

DEVEREUX SCHOOLS . . .

- mean 2500 acres of program space
- mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impaired children
- mean residential treatment centers, day treatment centers, and out-patient clinics
- mean vocational rehabilitation centers that provide bona-fide industry and training tasks
- mean specially designed programs in six states for 1800 students under the guidance of . . .



1800 staff members who carry the promise of happy tomorrows.

THE DEVEREUX FOUNDA[illegible]
DEVON, PA.

Sixty years of service to excep[illegible]nal children have reassured us that the latest educational tool is second to the value of the human resource.

A NON-PROFIT ORGANIZATION

Helena T. Devereux,
Founder and Consultant

Marshall H. Jarvis,
President

THE DEVEREUX FOUNDATION

FOR INFORMATION AND LITERATURE: Charles J. Fowler, Director of Admissions
Devereux Schools, Devon, Pennsylvania 19333

PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT
Ellwood M. Smith, Registrar, Devon, Pa. 19333

CALIFORNIA . . . . . Keith A. Seaton, Registrar, Box 1079, Santa Barbara 93102

TEXAS . . . . . William A. Gregoricus, Registrar, Box 2666, Victoria 77901

ARIZONA . . . . . Bette F. Eden, Ed.D., Director, 6404 E. Sweetwater, Scottsdale 85254

Vol. 130, No. 10 October 1973

THE AMERICAN JOURNAL OF PSYCHIATRY

This Month's Special Section

Women in Psychiatry and Medicine

Also in this issue

Official APA Reports

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Just a little reminder



Stelazine®
brand of
trifluoperazine HCl

Available in six dosage forms and strengths:

Tablets (1 mg., 2 mg., 5 mg., 10 mg.)

Injection (2 mg./ml.)

Concentrate (10 mg./ml.)

Manufactured and distributed by SK&F Co., Carolina, P.R. 00630.
Stelazine® trademark licensed by SmithKline Corporation, Philadelphia, Pa.

31.1.74

THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Journal of Psychiatry, formerly *The American Journal of Insanity*, is published monthly by the American Psychiatric Association. Editorial office: 1700 Eighteenth Street, N.W., Washington, D.C. 20009; telephone (202) 232-7878.

Subscriptions: U.S. $15.00 per year, Canada and South America $15.75, other foreign $18.00; single issues: $1.75 plus postage.

APA members should direct changes of address and communications about nonreceipt of the *Journal* to the Manpower Division, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

Communications from nonmember subscribers and all business communications should be directed to Mr. Robert J. Lowe, Publications Services Division, at the same address.

Advertising representatives: Steven K. Herlitz, Inc., 850 Third Avenue, New York, N.Y. 10022.

Type set by Bru-El Graphic, Inc., 5265 Port Royal Road, Springfield, Va. 22151.

Printed by Dartmouth Printing Co., 69 Lyme Road, Hanover, N.H. 03755.

Second class postage paid at Washington, D.C., and additional mailing offices.

Indexed in *Abstracts for Social Workers, Biological Abstracts, Chemical Abstracts, Cumulative Index to Nursing Literature, Excerpta Medica, Hospital Literature Index, Index Medicus, International Nursing Index, Nutrition Abstracts,* and *Psychological Abstracts.*

Copyright© 1973, the American Psychiatric Association.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers

Assistant Managing Editor
Amy E. Shaughnessy

Senior Assistant Editor
Linda A. Loy

Assistant Editors
Laura M. Little
James Johnson
Christine H. Duewel

Editorial Assistant
Katherine P. Olinick

Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.

THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 10 October 1973

1065 Community Mental Health Services in Britain
Douglas Bennett

1071 Epidemiological Differences Between White and Nonwhite Suicide Attempters
Andreas M. Pederson, George A. Awad, and Alan R. Kindler

1077 A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients
Sheldon H. Kardener, Marielle Fuller, and Ivan N. Mensh

1082 Psychiatry in Shanghai, China: Observations in 1973
David N. Ratnavale

1088 Evolving Behavior in the Clinical and Experimental Amphetamine (Model) Psychosis
Everett H. Ellinwood, Jr., Abraham Sudilovsky, and Linda M. Nelson

1094 The Dream-Protein Hypothesis
Ernest Lawrence Rossi

1098 Indian Education: A Human Systems Analysis
Carl A. Hammerschlag, Clayton P. Alderfer, and David Berg

1103 The Eclectic Approach to the Treatment of Phobias
K. Roy MacKenzie

1107 A Study of Prediction and Outcome in a Mental Health Crisis Clinic
Louis A. Gottschalk, Ruth A. Fox, and Daniel E. Bates

1112 The Therapeutic Utilization of the Juvenile Court
Yehuda Nir and Rhoda Cutler

SPECIAL SECTION: *Women in Psychiatry and Medicine*

1118 Women Psychiatrists in the United States
Maryonda Scher

1123 Medicine: A Career Conflict for Women
Malkah T. Notman and Carol C. Nadelson

1127 Women in Psychiatry: Past and Present Areas of Concern
Nancy A. Roeske

1131 Training the Woman Resident To Be a Psychiatrist
Elissa P. Benedek

EDITORIALS

1136 Women in Psychiatry
Rebecca Z. Solomon

1137 Benjamin Rush: Morality in Government
Robert E. Jones

BRIEF COMMUNICATIONS

1139 Drug Treatment of Depressed Patients Referred for Hospitalization
Joel Kotin, Robert M. Post, and Frederick K. Goodwin

1142 Single Versus Divided Daily Dose of Trimipramine in the Treatment of Depressive Illness
M.Z. Hussain and Z.A. Chaudhry

1144 "The Fitness Factory," Part I: The Psychiatrist's Role in Determining Competency
Robert Lloyd Goldstein

1148 Designing an Experientially Based Continuing Education Program
William H. Barber and Hugh James Lurie

1151 The Requirements of a Psychiatric Residency Program Circa 1972
Harvey Langee, Ira D. Glick, Browning Hoffman, Larry B. Silver, and Andrew P. Morrison

1153 The Clinical Case Conference Reconsidered
J. Regis McNamara

1155 Rapid Control of Psychotic Excitement States with Intramuscular Haloperidol
Francine SanGiovanni, Michael A. Taylor, Richard Abrams, and Pedro Gaztanaga

1157 Referral Failures: A One-Year Follow-Up
Walter A. Chameides and Joe Yamamoto

1159 LETTERS TO THE EDITOR

1164 BOOK REVIEWS

OFFICIAL ACTIONS

1177 Report of the Secretary

1184 Report of the Treasurer

1187 Report of the Medical Director

1189 Report of the Speaker

1191 Report of the Speaker-Elect

1193 1973 Annual Report of the American Board of Psychiatry and Neurology

1195 Proposed Amendments to the Constitution and By-Laws

A64 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of each article: 60–100 words for regular articles, 40–60 words for Brief Communications. The author may prepare the precis himself or ask that the *Journal* staff prepare it, in which case the author may make any necessary changes on the galley proofs.

References. References should be typed double-spaced on a separate sheet of paper, to be attached at the end of the manuscript. They should be arranged according to their order of appearance in the text, where they should be indicated by numbers in parentheses. Reference citations should be restricted to closely pertinent papers; a complete review of the literature is rarely desirable, except in the case of review articles for which a special arrangement has been made with the Editor.

References should be typed in accordance with the style shown below for books and journal articles; chapters in books will be treated as journal articles with regard to capitalization. Up to three authors should be listed; one or more authors past the third will be designated "et al." Abbreviations of journal names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and figures should be sufficiently clear that the meaning of the data is understandable without reference to the text. See recent issues of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attached at the end of the manuscript. The data should be arranged so that columns of like material read down, not across.

A complete set of figures, preferably in the form of glossy prints, should accompany each of the two copies of the manuscript. Most figures will be reduced to about 3¼ inches in width, the column width of the *Journal*; all elements of a figure should be prepared to withstand this reduction. Graphs should be finished drawings not requiring further artwork. Authors are urged to engage the services of a professional in the preparation of figures. Authors may be required to meet the costs of any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for corrections after the paper has been scheduled for publication; prompt return (preferably within 48 hours of receipt) is necessary to ensure publication in the assigned month. If an author expects to be away from his office for a long period of time after he has received the acceptance letter, he should inform the *Journal* office or arrange with a colleague to read the proofs. Authors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the galley proofs submitted to authors for correction. Reprints are usually mailed to authors about a month after publication of the article. Requests from others to order reprints should be directed to the Editor; inclusion of a letter of permission from the senior author and a brief statement of the intended use of the reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG, HERBERT KLEMMER, ALAN A. STONE, PERRY C. TALKINGTON

For two years: EWALD W. BUSSE, HENRIETTE R. KLEIN, MELVIN SABSHIN, JOHN R. SAUNDERS

For one year: ROBERT S. GARBER, JOHN E. NARDINI, IRVING PHILIPS, CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN

Constitution and By-Laws
WINFRED OVERHOLSER, JR.

Ethics
ROBERT A. MOORE

Membership
ALEXANDER LEVINE

Nominating
HOWARD P. ROME

Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN

History
DAVID F. MUSTO

Medical Education
HAROLD I. KAPLAN

School Consultation
SHELDON D. GLASS

Conference on Family Life Education
ARNOLD M. KALLEN

Graduate Education

Certification in Administrative Psychiatry
ARCHIE R. FOLEY

Research Training
FREDERIC G. WORDEN

Education of Physicians

Continuing Education Committee
ROBERT A. SENESCU

Continuing Education Task Force
JAMES NAIMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS

Psychiatry and the Law
STANLEY L. PORTNOW

Liaison with American Hospital Association
GERALD R. CLARK

Liaison with American College of Physicians
CHARLES P. NEUMANN

Psychiatric Nursing
WILLIAM E. STONE

Right to Treatment
BERNARD DIAMOND

Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN

Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER

Women in Psychiatry
NANCY A. ROESKE

Psychiatric Involvement in Family Planning
EUGENE B. BRODY

Psychosurgery
JOHN DONNELLY

Psychohistory
CHARLES HOFLING

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE

Drug Abuse
DANIEL X. FREEDMAN

Nomenclature and Statistics
HENRY BRILL

Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION

Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER

Lithium Therapy
IRVIN M. COHEN

Meditation
JAMES MORGAN

Effects of Television on Mental Health
JAMES H. RYAN

Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG

Joint Meeting in Australia 1975
ALFRED AUERBACK

Inter-American Council of Psychiatric Associations
HOWARD P. ROME

Psychological Aspects of Near Eastern Studies
WILLIAM D. DAVIDSON

Ethnocentricity Among Psychiatrists
RAMON PARRES

Transcultural Aspects of Mental Health of Children
JORGE M. VELASCO-ALZAGA

Liaison with International and Foreign Psychiatric Organizations
NATHAN S. KLINE

Joint Meeting with Scandinavian Psychiatric Societies
ROBERT S. GARBER

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON

Financing of Mental Health Care
WILLIAM H. GOLDMAN

Federal Government Health Services
STEWART BAKER

Childhood and Adolescence
VIOLA BERNARD

Private Psychiatric Hospitals
JOHN H. HOUCK

Suicide Prevention
MATHEW ROSS

Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD

APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON

Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE

Professional Standards Review Organizations
FRANK SULLIVAN

COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT

Program
H. KEITH H. BRODIE

Film Review
EDWARD A. MASON

Closed-Circuit TV Presentations
MILTON BERGER

Arrangements
BENJAMIN JEFFRIES

Conventions
ALEXANDER SIMON

Scientific Exhibits
ROBERT FROELICH

Awards for Scientific Exhibits
SARA DUBO

Public Information
JAMES P. CATTELL

Member Insurance and Retirement Plans
CHESTER TRENT

Trustees of APA Retirement Plan
SANFORD L. BILLET

House
DANIEL JAFFE

Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON

Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.

Isaac Ray Award
JOHN K. TORRENS

Manfred S. Guttmacher Award
JONAS R. RAPPEPORT

Hofheimer Prize
DONALD F. KLEIN

McGavin Award
NORBERT B. ENZER

Vestermark Prize
BERTRAM S. BROWN

Grants and Awards
JACK WEINBERG

Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL

Black Psychiatrists
JAMES P. COMER

Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT

Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ

Indian Affairs
MORTON BEISER

Comprehensive Health Planning
ROBERT L. WILLIAMS

Third-Party Intervention in Community Crises
FRANK OCHBERG

Legislative Network
HAYDEN H. DONAHUE

The balanced approach in adjunctive drug therapy



Especially relevant in psychiatric practice

Relief of obstructive anxiety through adjunctive drug therapy is often the means by which psychotherapeutic progress may resume. It is generally agreed, however, that for optimal benefit such anxiety should not be succeeded by a state of oversedation, with resultant flattening of emotional response.

For this reason, the benzodiazepines are widely preferred for reduction of excessive anxiety in psychoneurotic patients. They are considered among the safer, better-tolerated, less sedative of the effective antianxiety agents. In most cases, Librium (chlordiazepoxide HCl)—the first clinically applied benzodiazepine—provides the well-balanced effect frequently needed in treatment of overanxious office patients.

Librium (chlordiazepoxide HCl) dosage meets patient needs

The dosage schedule should have as its goal the relief of inappropriate anxiety. When that

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of

Antianxiety effect without loss of affect



has been accomplished, Librium (chlordiazepoxide HCl) therapy should be reduced, then discontinued. Experience has shown that, in proper dosage, Librium seldom impairs mental acuity, a particular advantage for ambulatory patients who must continue to perform daily activities. (See Warnings section below.) As with all CNS-acting agents, however, patients receiving Librium should be cautioned against activities requiring complete mental alertness.

In most instances, Librium (chlordiazepoxide HCl) promptly reduces inappropriate anxiety to levels necessary for normal performance. Thereby it helps expedite the psychotherapeutic process by freeing the patient to retrieve the repressed material which must be explored if he is to resolve his emotional conflicts.

In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of product information below.)

for control of inappropriate anxiety

Librium®
(chlordiazepoxide HCl)

10-mg, 25-mg capsules t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

For schizophrenic patients...

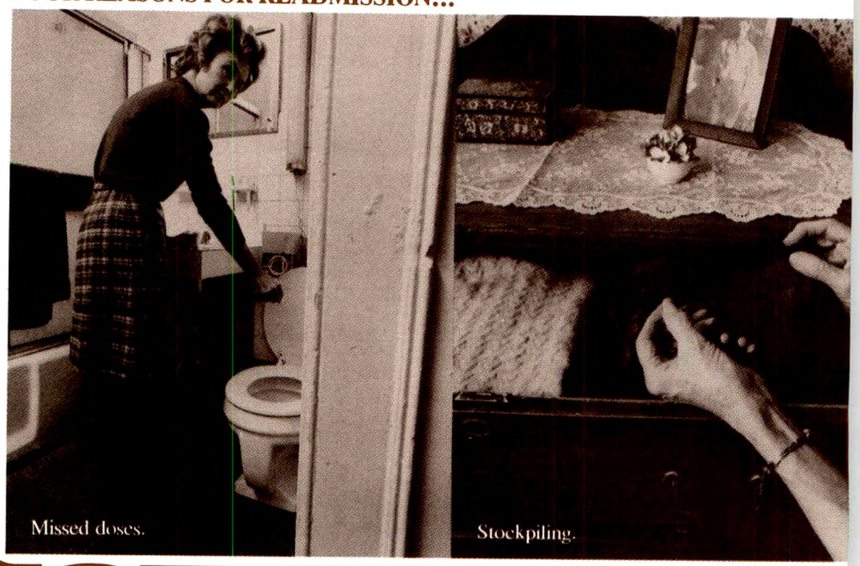
A way out

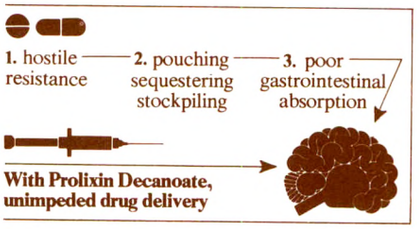
that helps them stay out

Controlled Drug Delivery with
PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)
Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer, with an average duration of effect of about 2 weeks

Controlled drug delivery helps prevent disruption of therapy—one of the commonest causes of psychotic relapse. For the inpatient it means unimpeded drug delivery with improved chances of discharge.

FOUR REASONS FOR READMISSION...





For the outpatient it means improve chances for prolonged remission: "...th duration of remission and the incidenc of relapse are directly related to keepin the patient medicated after his return t the community."[1]

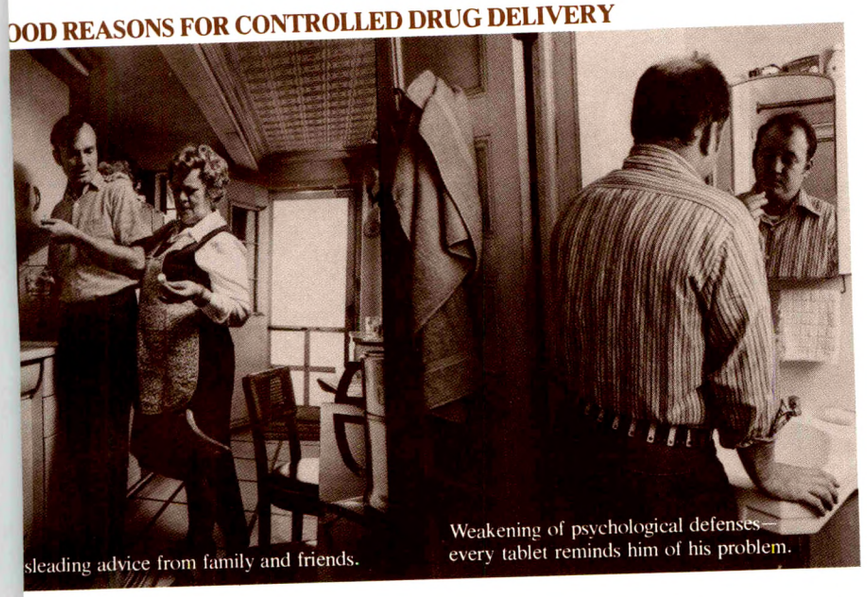
Controlled drug delivery helps the inpatient out

- Keeps the patient medicated...help make him more manageable, more cor fortable, and more amenable to tota treatment. With oral medication, on th other hand, approximately one out c every five patients does not take his me ication, even when administered by th nursing staff.[2]
- Eliminates the problem of missed, los or hidden doses. Prevents stockpiling.
- Assures regular medication intake.
- Lightens responsibilities of the hospita staff...simplifies patient management b obviating the need for multiple doses.
- Increases the likelihood of discharge In one study[3] of 24 long-term hospita patients treated with Prolixin Decanoat (Fluphenazine Decanoate Injec tion) every 7 days to 3 weeks:

DISCHARGED	CONSIDERED DISCHARGEABLE	NO IMPROVEMENT
13	4	7

Dischargeability "may also have been en hanced because the staff, the patien and the family were assured of an ac equate and regular medication intake."[3]

OOD REASONS FOR CONTROLLED DRUG DELIVERY



sleading advice from family and friends.

Weakening of psychological defenses—every tablet reminds him of his problem.

ontrolled drug delivery helps keep e outpatient out

Helps assure continuity of medication .makes prolonged remission more kely. With oral medication, on the her hand, "approximately 50% of all scharged psychotic patients fail to take ven the first dose of their outpatient edication."[2]

Enhances chances for rehabilitation... romotes acceptance socially, in the mily, and on the job because of sus- ained control of symptomatology.

Eases family adjustment by eliminating oncern about "taking his medicine."

Avoids the potential dangers of stock- iling, particularly for the suicidal.

Once administered, therapy cannot be ltered by the patient, by his family, or y anyone else.

The unique advantages of controlled rug delivery apply equally to the pa- ent who has never been hospitalized. They are advantages that can help make custodial care unnecessary as long as treatment continues.

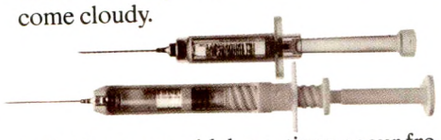
Controlled drug delivery saves time, reduces cost in the hospital, clinic, office

Saves time in the hospital:

18 PATIENTS	18 PATIENTS
	
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Saves time in the clinic and in the office: Most patients report for their injections only once in every two-week period.

Prolixin Decanoate (Fluphenazine Decanoate Injection) also offers the convenience of easy-to-use Unimatic® Syringes: Unimatic single-dose preassembled syringes and Unimatic cartridge-needle units with a reusable plastic holder. Vials of 5 cc. Prolixin Decanoate are available for use with dry syringes and needles (at least 21 gauge). Use of a wet needle may cause the solution to become cloudy.



N.B. Extrapyramidal reactions occur frequently. Most often they are reversible and can usually be controlled by administration of antiparkinsonian drugs. However, in some instances, they are persistent—particularly in the case of tardive dyskinesia (see Adverse Reactions section of Brief Summary). Patients should be forewarned and reassured.

References: 1. Kinross-Wright, V. J.: Cited in Med. Tribune, Sept. 13, 1965, pp. 1, 27. 2. Goldberg, H. L., DiMascio, A. and Chaudhary, B.: Psychosomatics 11:173, May-June 1970. 3. Keskiner, A. et al.: Arch. Gen. Psychiatry 18:477, Apr. 1968. 4. Platt, R.: Br. J. Social Psychiatry 2:187, 1968.

Controlled Drug Delivery *with* PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)

For product Brief Summary, see following page.

SQUIBB HOSPITAL DIVISION

Controlled Drug Delivery

in schizophrenia with

PROLIXIN® DECANOATE

(FLUPHENAZINE DECANOATE INJECTION

BRIEF SUMMARY
Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy. Safety and efficacy in children have not been established because of inadequate experience in use in children.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anticholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of antiparkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight chang peripheral edema, abnormal lactation, gynec mastia, menstrual irregularities, false resul on pregnancy tests, impotency in men an increased libido in women have occurre in some patients on phenothiazine therap

Allergic Reactions—Itching, erythema, ur caria, seborrhea, photosensitivity, eczem and exfoliative dermatitis have been reporte with phenothiazines. The possibility of an phylactoid reactions should be borne in min

Hematologic—Blood dyscrasias includin leukopenia, agranulocytosis, thrombocyt penic or nonthrombocytopenic purpur eosinophilia, and pancytopenia have bee observed with phenothiazines. If soreness o the mouth, gums or throat or any symptom of upper respiratory infection occur and co firmatory leukocyte count indicates cellula depression, therapy should be discontinue and other appropriate measures institute immediately.

Hepatic—Liver damage manifested by ch lestatic jaundice, particularly during the firs months of therapy, may occur; treatmen should be discontinued. A cephalin floccul tion increase, sometimes accompanied by alterations in other liver function tests, ha been reported in patients who have had n clinical evidence of liver damage.

Others—Sudden deaths have been reporte in hospitalized patients on phenothiazine Previous brain damage or seizures may b predisposing factors. High doses should b avoided in known seizure patients. Shortly before death, several patients showed flar ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulm nating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial l sions. Although not a general feature of flu phenazine, potentiation of central nervous system depressants such as opiates, analg sics, antihistamines, barbiturates, and alco hol may occur.

Systemic lupus erythematosus-like syn drome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardio graphic and electroencephalographic tracings altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angio neurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 cc. Unimatic® single dose preassembled syringes and cartridge needle units, and 5 cc. vials.

SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H423-023
Princeton, N. J. 08540

mirror, mirror on the wall, can this hospitalized schizophrenic relate to herself at all?





If the answer is "yes,"

then she can be helped to relate to others with the adjunctive use of

Trilafon®

brand of
perphenazine, NF

TRILAFON®
brand of perphenazine, NF
Tablets
REPETABS® Tablets
Syrup Concentrate Injection

CONTRAINDICATIONS TRILAFON is contraindicated in drug-associated central nervous system depression (barbiturates, alcohol, narcotics, analgesics, antihistamines). Perphenazine is contraindicated in the presence of existing blood dyscrasias, bone marrow depression and pre-existing liver damage, and in patients who are hypersensitive to perphenazine.

TRILAFON Injection should not be given to patients in coma or severely depressed states.

WARNINGS Usage in pregnancy: Perphenazine should only be given to pregnant patients when, in the judgment of the physician, the potential benefits outweigh the possible risks.

Perphenazine can lower the convulsive threshold in susceptible individuals; it should be used with caution in patients with convulsive disorders. If the patient is being treated with an anticonvulsant agent, increased dosage of that agent may be required when perphenazine is used concomitantly.

Perphenazine should be used with caution in patients with psychic depression.

Perphenazine is not recommended for children under 12 years of age.

Perphenazine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or oper machinery.

PRECAUTIONS As with any potent medication, patients receiving perphen should be under medical supervision, particularly if they are receiving doses. Patients who have had any severe reaction to phenothiazines or to pramine should be treated cautiously, under close medical supervision.

Although the following adverse reactions have not been reported in pat treated with perphenazine, the possibility that they might occur with TRIL should be considered; blood dyscrasias (pancytopenia, thrombocytopenic pur leukopenia, eosinophilia); liver damage (biliary stasis); narrowing of the v fields; pigmentation of the retina, cornea, or lens; cerebral edema; polyph photophobia; hyperpyrexia.

If hypotension develops, levarterenol (norepinephrine) can be used, bu epinephrine, because epinephrine's action is blocked and partly reversed by phenazine. Severe, acute hypotension has occurred with the use of phen zines and is of particular concern in patients with mitral insufficienc pheochromocytoma.

A significant rise in body temperature may indicate an idiosyncratic rea to perphenazine; treatment with perphenazine should be stopped if this oc

The antiemetic effect of perphenazine can obscure signs of toxicity du overdosage of other drugs, or mask the symptoms of disease (eg, brain tum intestinal obstruction).

Contact dermatitis has been reported with a perphenazine solution; there contact of hands or clothing by those handling perphenazine solutions sl be avoided.

POTENTIATION Since phenothiazines can potentiate the central-nervous-sys depressant actions of opiates, antihistamines, barbiturates, and alcohol,

Schering

Tablets 2,4,8,16 mg. REPETABS® 8 mg.	for maintenance therapy with cooperative patients
Concentrate 16 mg./5 cc. 4 oz. bottle with calibrated dropper	for "cheeking," geriatric, confused or otherwise untrustworthy psychotic patients
Injection 5 mg./cc., 10 cc. multiple-dose vial, 1 cc. ampule	for emergency or initial treatment of agitated psychotics



A potent phenothiazine to help:

- maintain alertness level
- stabilize behavioral patterns
- relieve anxiety/agitation
- increase patient response to psychotherapy

Trilafon®

brand of

perphenazine, NF

a major tranquilizer for in-hospital control and take-home therapy

---

the usual dosage of these agents is required when they are administered imitantly with TRILAFON. Patients should be cautioned that their response cohol may be increased while they are being treated with TRILAFON.
enothiazines also potentiate the effects of atropine, heat, and phosphorus ticides, and should be used with caution in persons exposed to these agents.

RSE REACTIONS *Extrapyramidal reactions:* dystonia including protru- discoloration, aching and rounding of the tongue; tonic spasm of the mas- ory muscles, tight feeling in the throat, slurred speech, dysphagia, oculogyric , trismus, torticollis, retrocollis, muscle weakness, and aching and numb- of the limbs; akathisia; motor restlessness; dyskinesia, parkinsonism; reflexia; and ataxia. The incidence and severity of these reactions usually ase with increased dosage, but have occurred in some patients receiving losage. Reduction in dosage or treatment with an antispasmodic agent will ly control extrapyramidal reactions. In some instances, however, these ions may persist after discontinuation of treatment with perphenazine.
rsistent tardive dyskinesia: As with all antipsychotic agents, tardive dys- ia may appear in some patients on long-term therapy or may appear after therapy has been discontinued. The risk appears to be greater in elderly nts on high-dose therapy, especially females. The symptoms are persistent n some patients appear to be irreversible. The syndrome is characterized by mical involuntary movements of the tongue, face, mouth or jaw (eg, pro- on of tongue, puffing of cheeks, puckering of mouth, chewing movements). etimes these may be accompanied by involuntary movements of extremities. e is no known effective treatment for tardive dyskinesia; antiparkinsonism ts usually do not alleviate the symptoms of this syndrome. It is suggested all antipsychotic agents be discontinued if these symptoms appear. Should necessary to reinstitute treatment, or increase the dosage of the agent, or h to a different antipsychotic agent, the syndrome may be masked. It has reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time the syndrome may not develop.

Allergic reactions: erythema, pruritus, urticaria, eczema, anaphylactoid reactions, and local and generalized edema. In extremely rare instances, individual idiosyncrasy or hypersensitivity to phenothiazines has resulted in cerebral edema, circulatory collapse, and death. Photosensitization, asthma, and exfoliative dermatitis have also occurred in patients treated with phenothiazines.

Autonomic reactions: blurred vision, dry mouth or salivation, nasal congestion, nausea, vomiting, hypertension, tachycardia, hypotension, anorexia, urinary frequency or incontinence, and constipation. Significant autonomic effects have been infrequent in patients receiving less than 24 mg. perphenazine daily.

Other reactions: endocrine disturbances (lactation, gynecomastia, galactorrhea, disturbances in the menstrual cycle), headaches, mild insomnia, altered cerebrospinal fluid proteins, ECG abnormalities, reactivation of psychosis, paradoxical excitement, paranoid-like reactions, catatonia, and systemic lupus erythematosus-like syndrome. Hypnotic effects appear to be minimal, particularly in patients who are permitted to remain active. The following adverse reactions, though rare, have also been reported to be associated with perphenazine treatment: agranulocytosis; jaundice; hyperpigmentation of the skin; grand mal convulsions; failure of ejaculation; hyperglycemia.

Side effects with intramuscular TRILAFON Injection have been infrequent and transient. Dizziness or significant hypotension after treatment with TRILAFON Injection is a rare occurrence.

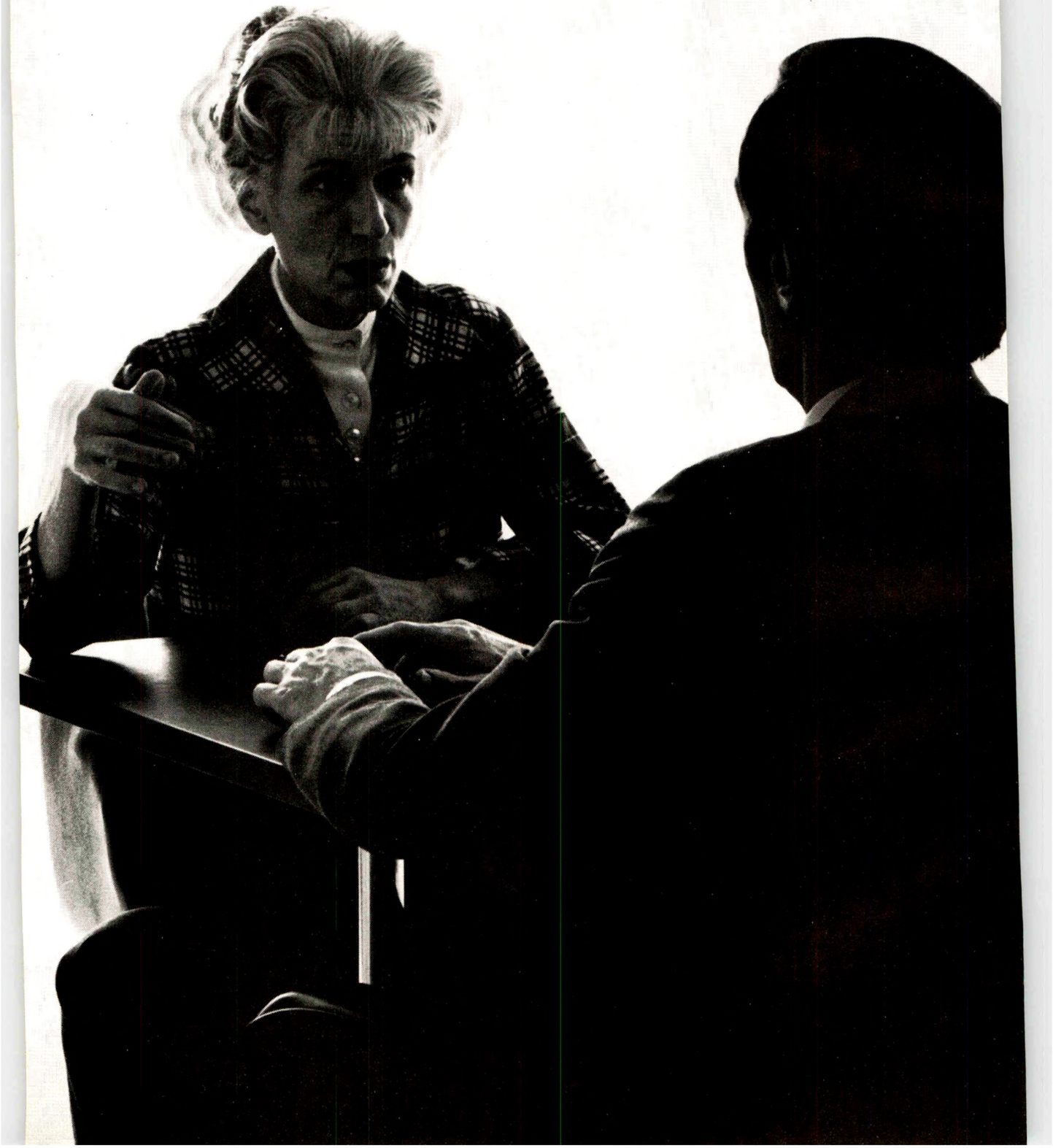
NOVEMBER 1972

Schering

Schering Corporation, Bloomfield, N.J. 07003

SWW-270

patients most in need of phenothiazines are often least able to cope with their side effects



TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)

added to the regimen helps alleviate phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia or hypotension and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Benztropine Mesylate, MSD) if they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000. Injection, containing 1.0 mg benztropine mesylate and 9.0 mg sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

addendum

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Extrapyramidal symptoms that develop slowly usually are less responsive. They may require more prolonged treatment with 2 to 6 mg a day.

For more detailed information, see full prescribing information.

Director

Out-Patient Service: $28,000 - $32,100

Thistletown Regional Centre for Children and Adolescents, MINISTRY OF HEALTH, located in northwestern Metro Toronto, requires a Senior Child Psychiatrist to assume leadership of the Out-Patient and Community Services.

The Centre provides in-patient, out-patient and day treatment services to emotionally disturbed children and adolescents and is affiliated with the Department of Psychiatry, University of Toronto, as a training centre in child psychiatry. The Out-Patient Department has been enlarged with a new wing with modern teaching facilities.

Alternative professional contract engagement also available at $27,000-$34,000 per annum.

Qualifications: Licensed to practice in Ontario or eligible for such license; certification by the Royal College of Physicians and Surgeons in Psychiatry or eligible for such certification; considerable child psychiatric clinical experience.

Please write to: **Clinical Director, Thistletown Regional Centre for Children and Adolescents, 11 Farr Avenue, Rexdale, Ontario, Canada. M9V 2A5**

Ontario **Ontario Public Service**

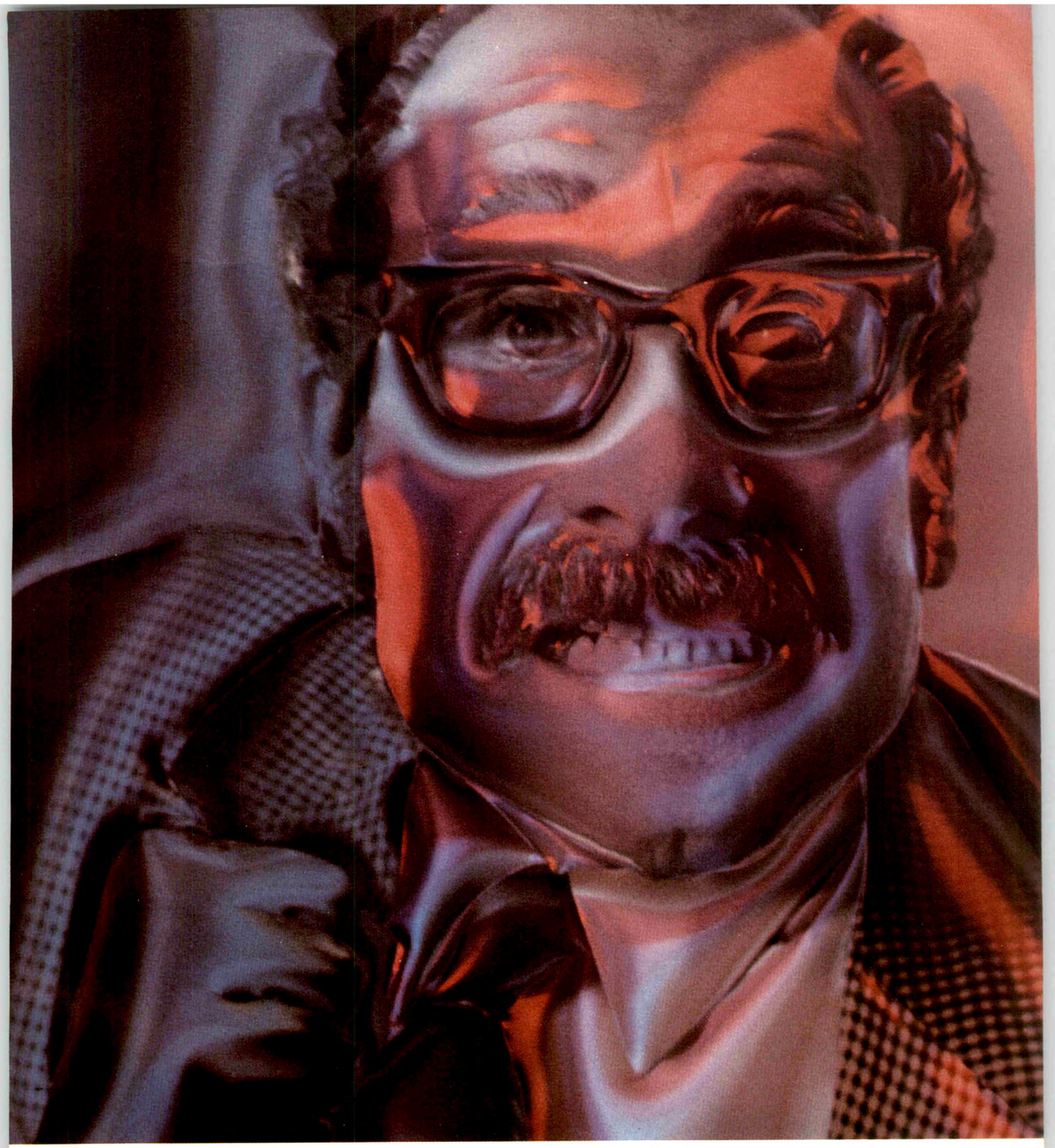
The American Journal of Psychiatry

The November 1973 issue will feature

Judd Marmor on

The Future of

Psychoanalytic Therapy



Agitated and hyperactive?...Or cooperative?

While psychotic symptoms remain acute, the barrier between you and the agitated, hyperactive patient may be insurmountable. Prompt intervention with HALDOL (haloperidol) often makes it possible for you to reach... relate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

cooperation often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

© MCNEIL LABORATORIES, INC., 1973

Haldol®
(HALOPERIDOL)
a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: HALDOL (haloperidol) is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 6/73

McNEIL McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

from USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows... maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models— **PORTABLE FOR OFFICE AND CLINIC**



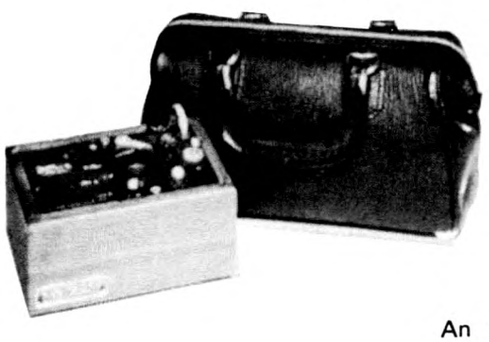
The Reiter MODEL SOS—THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives—patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes —a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

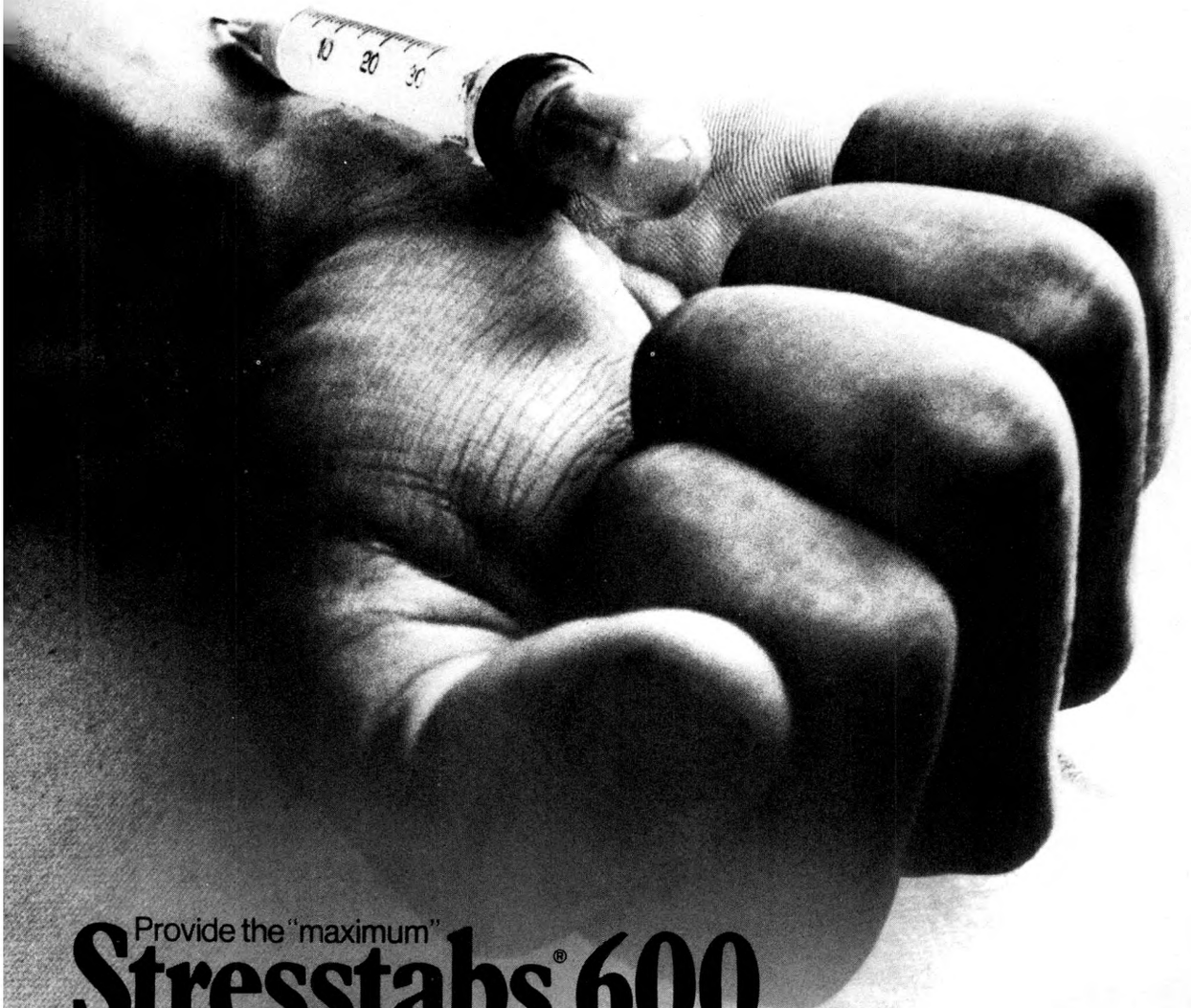
An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

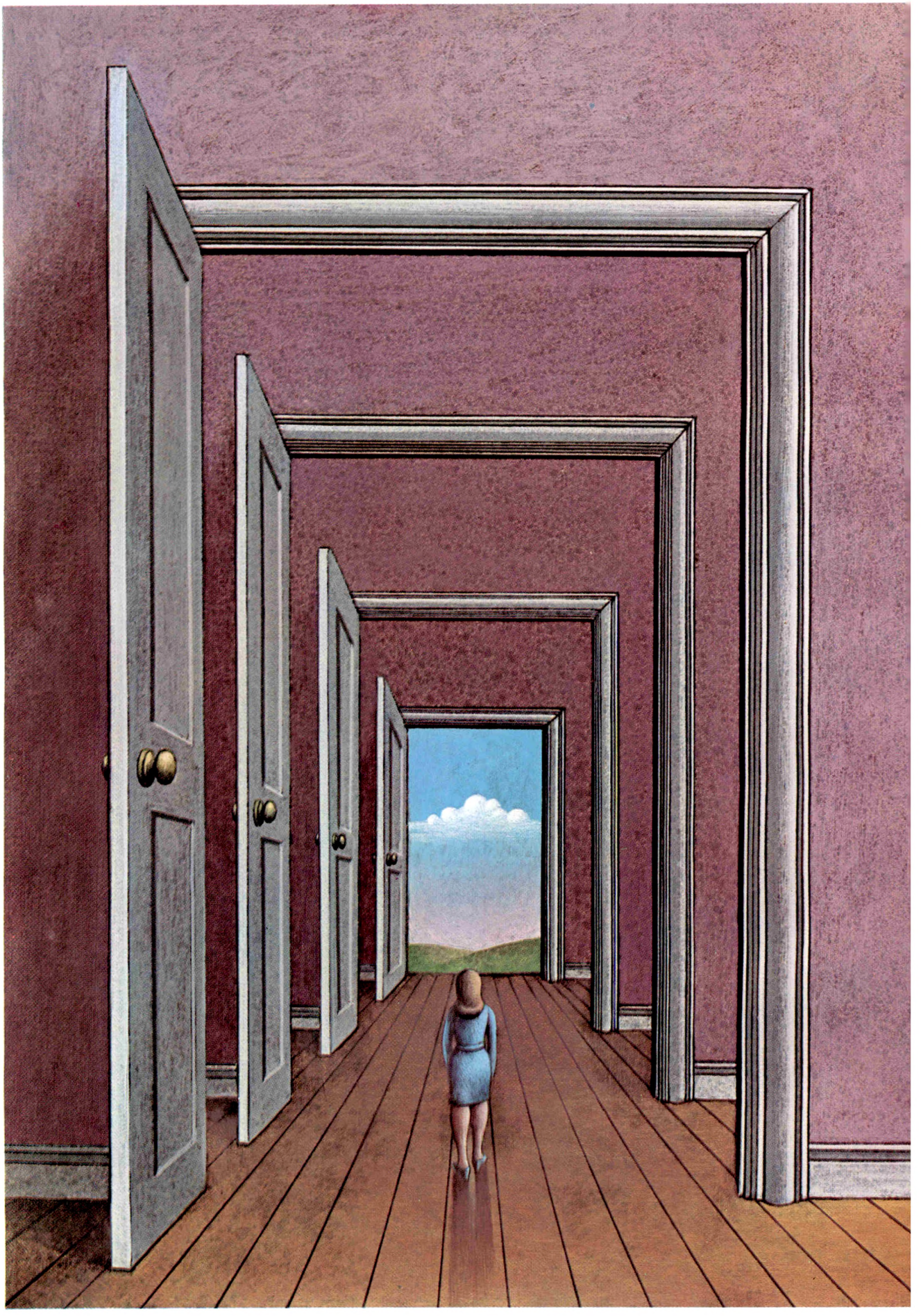
High Potency Stress Formula Vitamins

Each Tablet Contains:

Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3



A22

A HEAD START FOR THE CLINICALLY DEPRESSED PATIENT.

All tricyclic antidepressants take om one to four weeks before optimal ntidepressant effect is seen.

Sinequan (doxepin HCl)—the newest icyclic antidepressant—is no exception.

But, in that waiting period, Sinequan ffers the clinically depressed atient both:

prompt sedative activity to begin relieving the sleep disturbances often characteristic of depression, and

marked antianxiety activity to help relieve the apprehension, tension, worry and fear that usually accompany depression.

Further, the incidence of cardiovascular side effects with Sinequan is relatively low. Tachycardia and hypotension are infrequent. (Drowsiness is the most common side effect.) And Sinequan, unlike other tricyclic antidepressants, does not generally affect the activity of guanethidine and similarly acting compounds at usual clinical doses.

Prompt sedative activity. Marked antianxiety activity. Low incidence of cardiovascular side effects.

It's a head start for the clinically depressed patient.

HE NEWEST TRICYCLIC ANTIDEPRESSANT– VITH DIFFERENCES YOU CAN SEE.

Sinequan®
)OXEPIN HCl
5-mg. and 50-mg. capsules

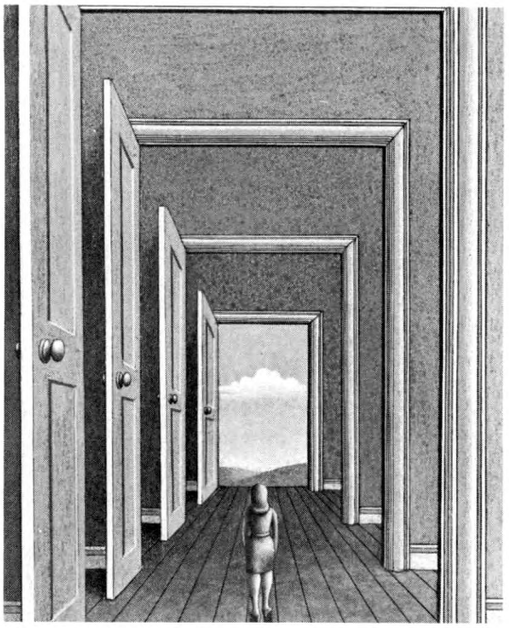
Pfizer **LABORATORIES DIVISION**
PFIZER INC.

(See Brief Summary on following page for information on adverse reactions, contraindications, warnings and precautions.)

3, PFIZER INC.

Sinequan®
DOXEPIN HCl
25-mg. and 50-mg. capsules

THE NEWEST TRICYCLIC ANTIDEPRESSANT–WITH DIFFERENCES YOU CAN SEE.



BRIEF SUMMARY
Sinequan®(doxepin HCl) **Capsules**
Contraindications. Sinequan (doxepin HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) w similar to the other structurally related psychotherapeutic agents as regards i ability to potentiate norepinephrine response in the animal. However, in t human this effect was not seen. This is in agreement with the low incidence the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and co stipation have been reported. They are usually mild, and often subside wi continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usual occurs early in the course of treatment, and tends to disappear as therapy continued.

Cardiovascular Effects: Tachycardia and hypotension have been reporte infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gas trointestinal reactions, secretory effects such as increased sweating, weakness dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increase or decreased at appropriate intervals and according to individual response. Th usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100 and 1000.

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
PFIZER INC.

OXFORD

Brain's Clinical Neurology

Fourth Edition

Revised by ROGER BANNISTER, St. Mary's Hospital, London. ☐ In this revision Dr. Bannister has paid particular attention to two areas: virus diseases of the nervous system and "geographical neurology." New material on genetic mechanisms, optic atrophy, physiology of the cerebral circulation and the histochemistry of muscle disease has been added. The text describes new isotope techniques for measuring cerebral blood flow, and myelographic techniques using air and the supine position.

1973 456 pp. 136 illus. cloth $18.50 paper $11.50

Society, Stress and Disease

Volume I: The Psychosocial Environment and Psychosomatic Diseases

Edited by LENNART LEVI, M.D., Karolinska Hospital, Stockholm ☐ "The book presents a multitude of problems in a comprehensive and stimulating fashion. . . . It should be worthwhile reading for any physician interested in the welfare of his patient and the factors that might influence his health. The book widens our horizons by bringing into focus problems that must be solved if we are to live in harmony with changing social forces." —William Ransohoff, M.D., *Annals of Internal Medicine*

1972 480 pp. 134 illus. $29.95

Early Human Development

Edited by S. J. HUTT and CORINNE HUTT, both of the University of Keele. ☐ These twenty-nine articles, with linking text, trace human development during the first four years of life, a time when biological factors are especially powerful, and during which the foundations of later intellect and personality are laid. Readings have been chosen not only from psychological, but also from biological, endocrinological, and physiological sources.

1973 372 pp. 55 illus. paper $9.50

An Introduction to Psychopathology

Third Edition

D. RUSSELL DAVIS, University of Bristol. ☐ For psychiatrists seeking explanations for their clinical problems and psychologists seeking practical applications for their research work, this text will bridge the gap between the psychiatric clinic and the psychological laboratory. The volume explains mental disorders in psychological terms and by reference to family processes and social experience.

1973 180 pp. paper $5.95

Interviewing and Patient Care

ALLEN J. ENELOW, M.D., Pacific Medical Center, University of the Pacific, and SCOTT N. SWISHER, M.D., Michigan State University, College of Human Medicine. ☐ "Very well organized text for first year medical students—especially helpful because of the material on the problem oriented record and on interviewing of children and families as well as usual adult patient interviewing."—Donald G. Langsley, M.D., University of California Davis School of Medicine

1972 240 pp. cloth $7.50 paper $3.95

Behavior Modification of the Mentally Retarded

Edited by TRAVIS THOMPSON, University of Minnesota, and JOHN GRABOWSKI, University of Southern California. ☐ This is an excellent book which should be read by everyone who works with retarded people in residential or day care settings."—Robert C. Colligan, *Mayo Clinic Proceedings*. "This is an important book of great consequence to those working in the field of mental handicap."—B. H. Kirman, *British Journal of Psychiatry*

1972 320 pp. Cloth $7.50 paper $4.95

The Genetics of Mental Disorders

ELIOT SLATER and VALERIE COWIE, Queen Mary's Hospital for Children, Carshalton, "The book is beautifully put together, with liberal use of tables, figures, and photographs. ☐ The authors' sophistication and the firm grasp of their field are apparent throughout. . . . Clearly, this book will go a long way toward meeting the need to disseminate such information to all interested readers."—*The Journal of Nervous and Mental Disease*

1971 422 pp. 65 illus. $25.00

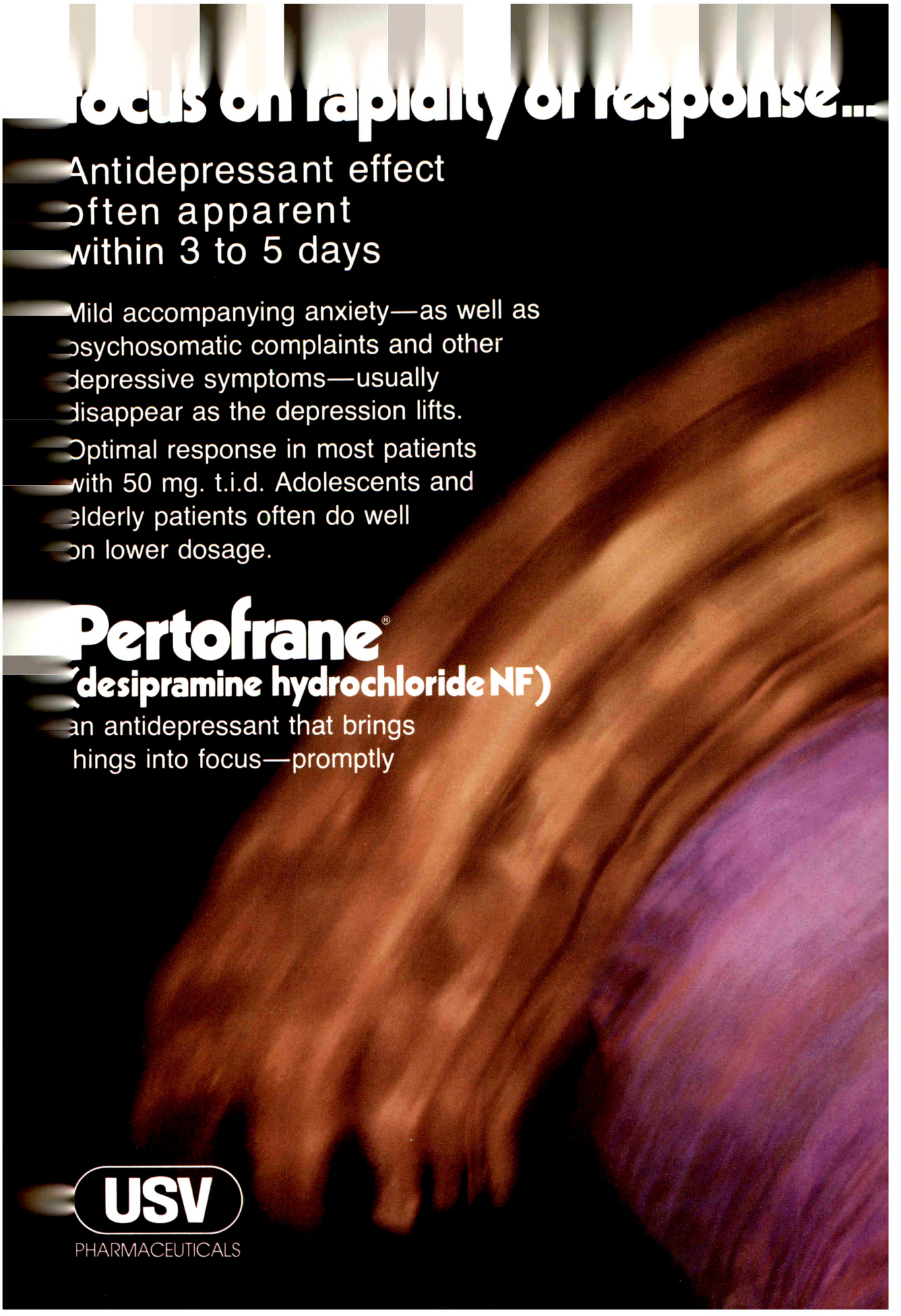
Roots of Evaluation

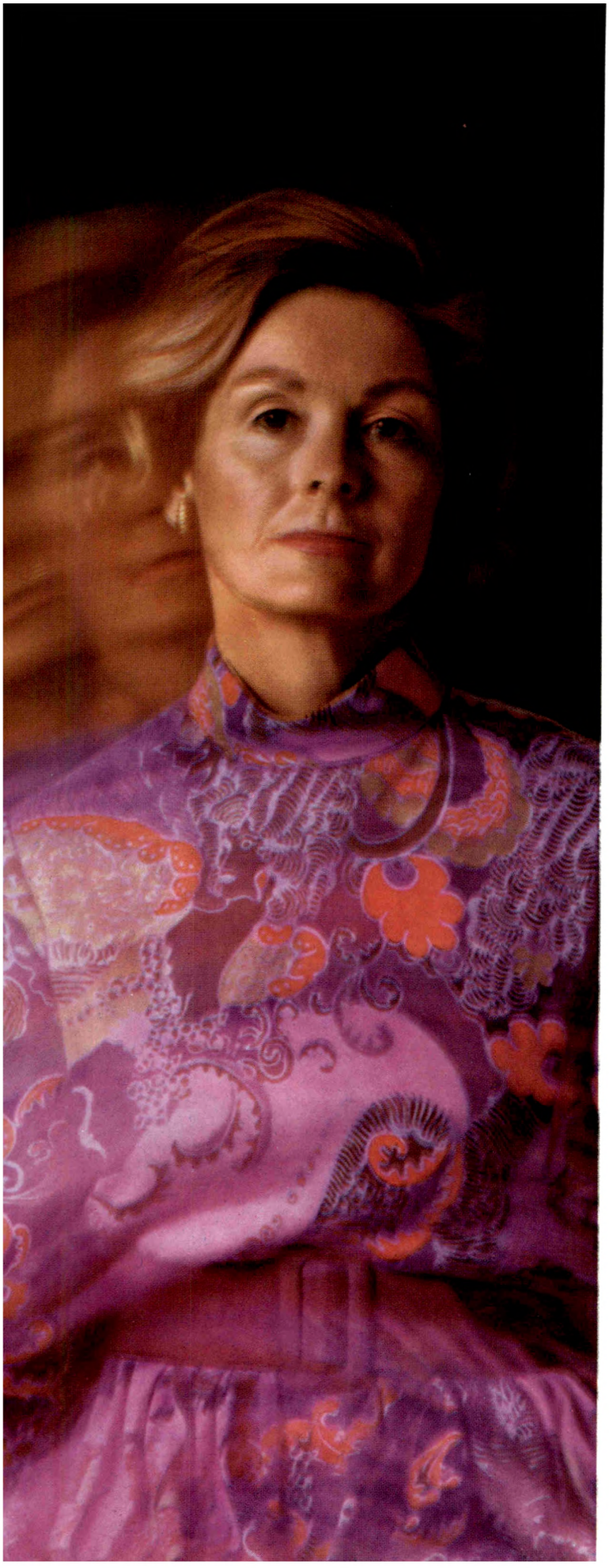
An Epidemiological Basis for Planning Psychiatric Services

J. K. WING and H. HAFNER. ☐ In most countries with extensive health services there is a growing awareness that further development must be based on rational principles and careful planning. This book summarizes research carried out to date, in Europe and the United States, into services for the mentally ill, the intellectually retarded and the elderly mentally ill.

Fall 1973 450 pp. $32.50

OXFORD UNIVERSITY PRESS
200 MADISON AVENUE
NEW YORK, N.Y. 10016

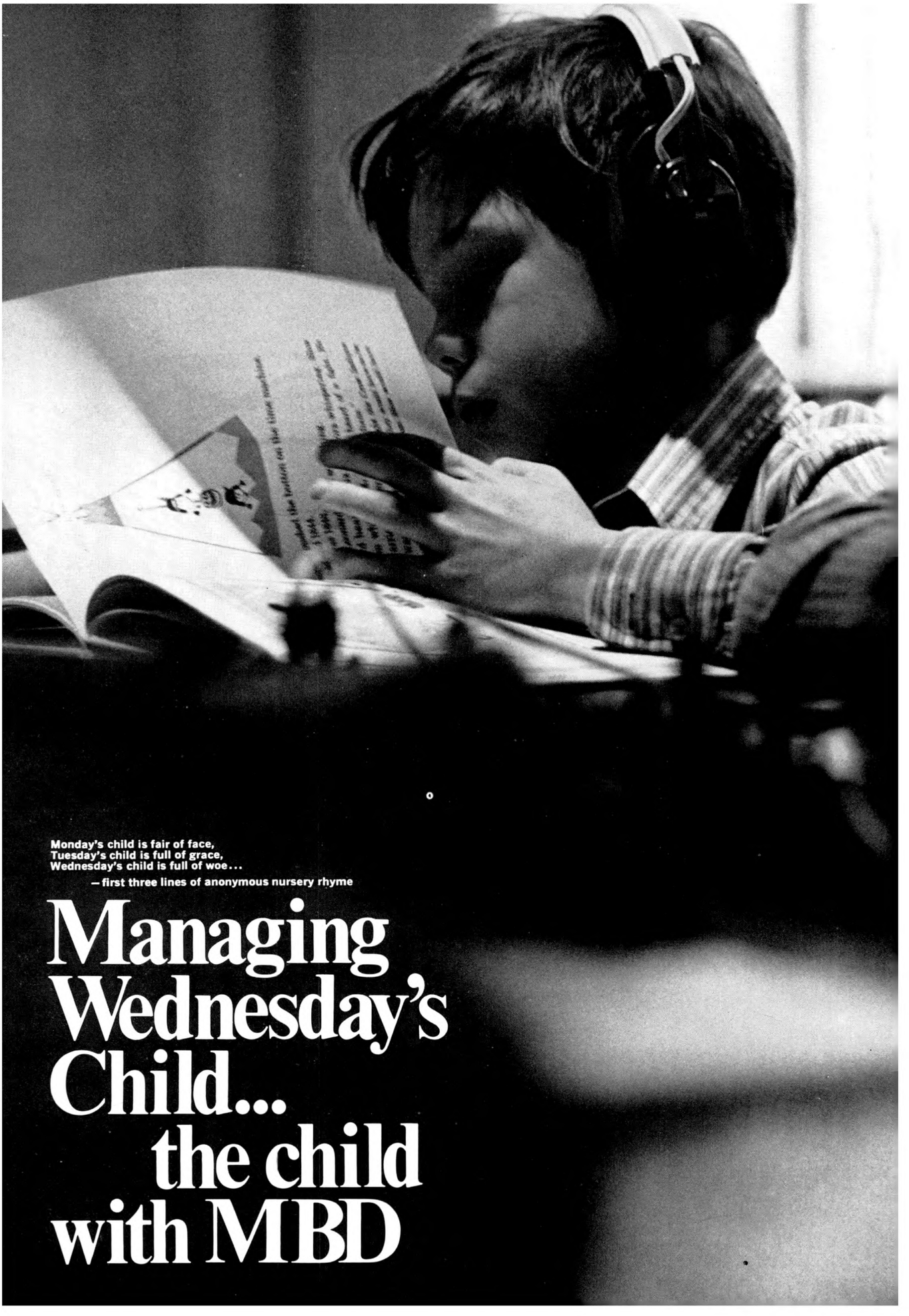

Focus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS



Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe" It need not be this way for the MBD child. He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD —Minimal Brain Dysfunction—can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference

1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

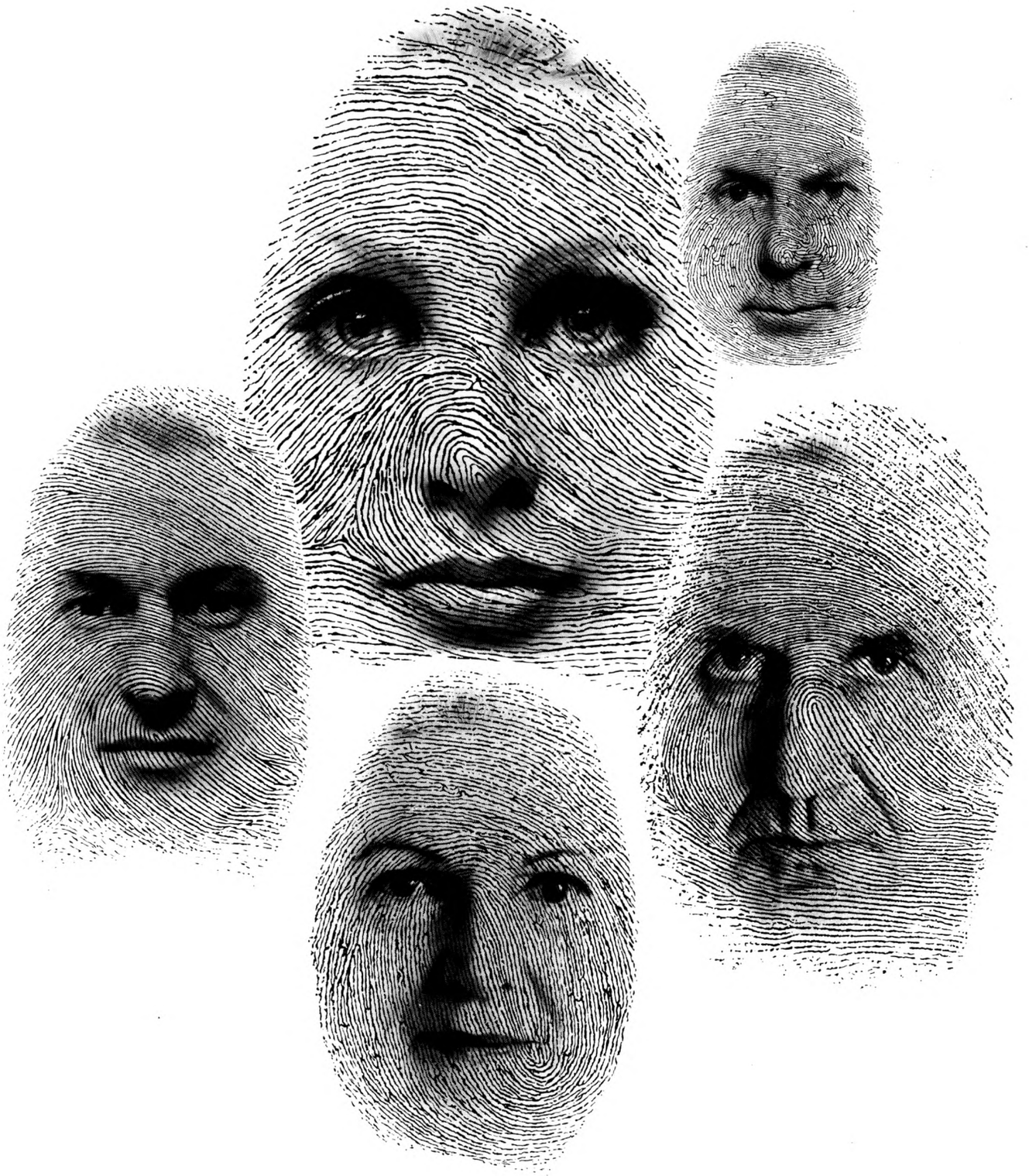
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

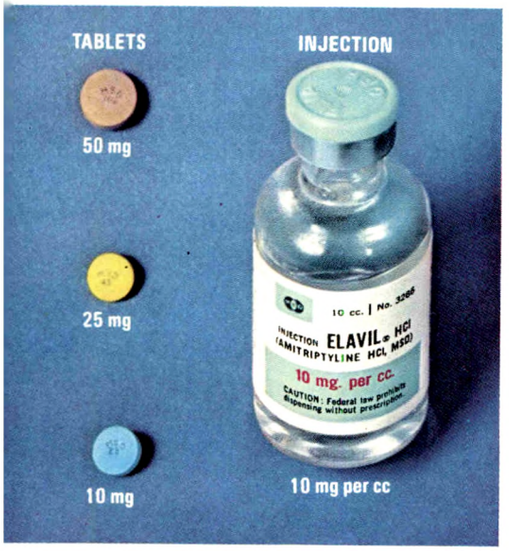
Ritalin®
(methylphenidate)
only when medication is indicated

C I B A

No two depressed patients are exactly alike...



but for many patients with clinically significant depression you'll find a useful dosage form of



ELAVIL®
(AMITRIPTYLINE HCl | MSD)

ELAVIL should not be used during the acute recovery phase following myocardial infarction, in patients hypersensitive to it, or in those who have received an MAOI within two weeks. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Concurrent electroshock therapy may increase hazards associated with such therapy. Patients with cardiovascular disorders should be watched closely. The drug may impair mental or physical abilities required in hazardous tasks and may potentiate the effects of alcohol.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

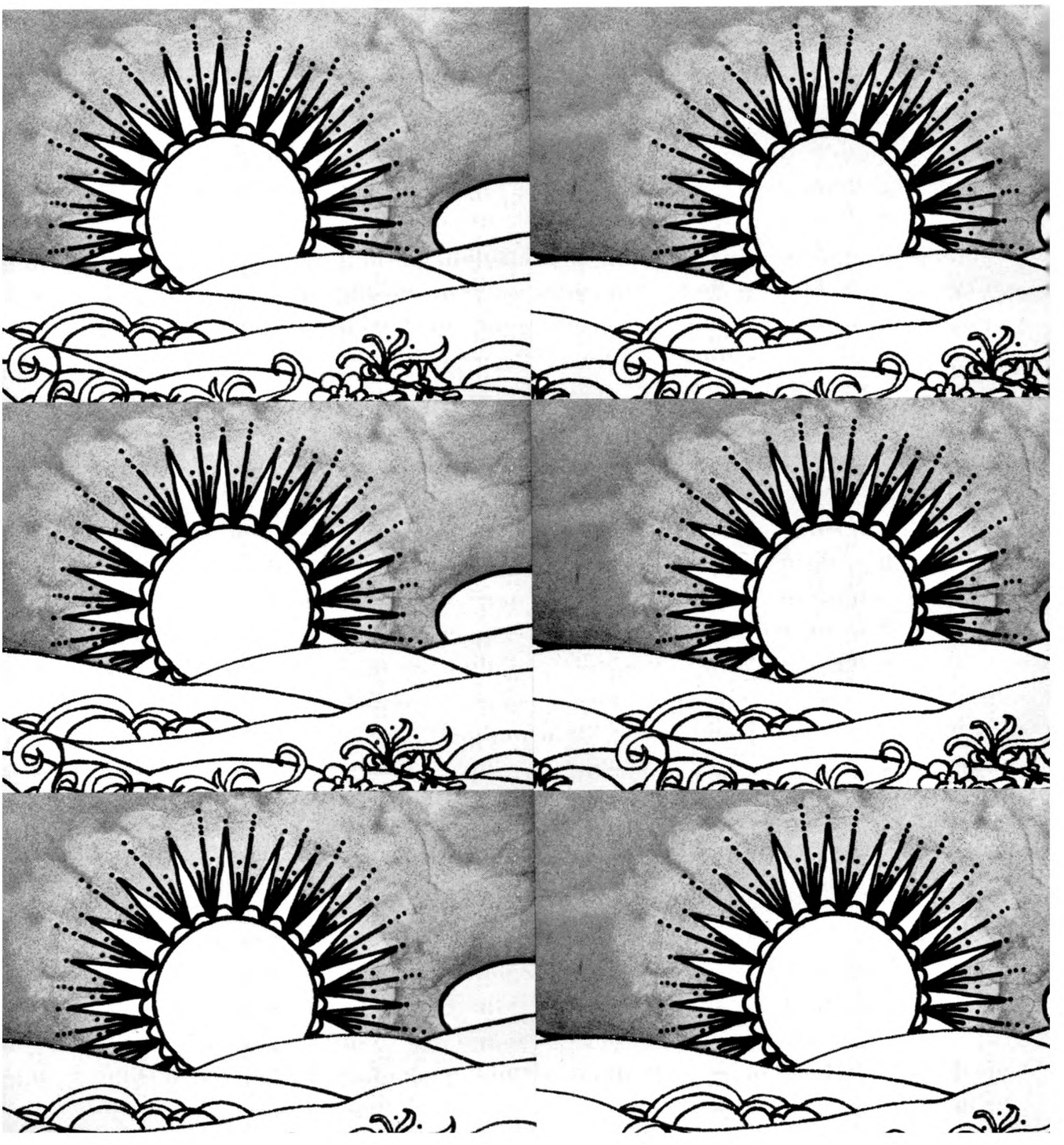
Overdosage: The intravenous administration of 1–3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

MSD
MERCK SHARP & DOHME

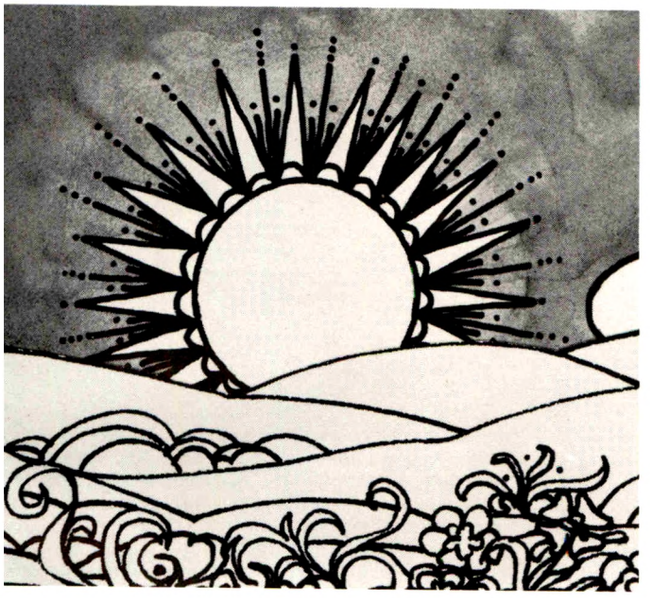
For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

The new-day constant for drug-induced parkinsonism:



ARTANE®
TRIHEXYPHENIDYL HCl

Non-cumulative action makes each day of therapy a new day



That's why ARTANE is ideally suited for the patient on long-term phenothiazine therapy. In economical tablets or SEQUELS Sustained Release Capsules*, it offers you *more* than the rapid reversal of extrapyramidal symptoms.

Usually there is no drug buildup to cause undue toxicity in prolonged therapy. Minimal atropine-like side effects. Accurate dosage titration in adjunctive use. And, to minimize missed doses and anxiety in outpatient therapy— one-dose *all-day* control or prevention with SEQUELS.*

For hospitalized or ambulatory patients, ARTANE has the "constant" they need. Effective *non-cumulative* action.

ıblets—2 mg, 5 mg; Elixir†—2 mg/5 cc or SEQUELS® Sustained Release Capsules—5 mg.

blets and Elixir Indications: FDA has evaluated this drug as Effec- e as an adjunct in the therapy of the indications listed below der SEQUELS.

INDICATIONS FOR ARTANE SEQUELS:
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/ or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms f parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine nd phenothiazines.

RNING:
ents to be treated should have a gonioscope evaluation and e monitoring of intraocular pressures at regular periodic intervals.

autions: Patients with cardiac, liver or kidney disorders or with rtension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated.

Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache.

†Lime-mint flavored, with 0.08% methylparaben, 0.02% propylparaben, and 5% alcohol as preservatives.

drug in sustained release form has been evaluated as probably effective. See Brief Summary.

ederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

716-3

A33



First day in the hospital and all efforts will be directed toward returning her to the community.

For psychotic patients with mixed anxiety-depression, Mellaril has been found useful to help patients participate more fully in the entire therapeutic program. Continued medication with Mellaril is often basic to helping patients prepare for and participate in outpatient treatment programs that bridge the gap between hospital and community.

With Mellaril, patients are generally alert and in better contact with reality and can more fully benefit from the entire therapeutic program. (In the hospital or out, even though Mellaril produces only minimal sedative effect, patients should be warned about participating in activities which require complete mental alertness, e.g., driving.) And, although extrapyramidal symptoms are characteristic of this class of drug, a distinctive feature of Mellaril is that extrapyramidal stimulation —notably pseudoparkinsonism—is minimal.

MELLARIL®
(THIORIDAZINE)

TABLETS: 25 mg., 50 mg., 100 mg., 150 mg., and 200 mg. thioridazine HCl, U.S.P.

helps in the management of psychotic patients with mixed anxiety-depression

A34

Before prescribing or administering, see Sandoz literature for full prod information. The following is a brief summary.

Contraindications: Severe central nervous system depressio comatose states from any cause, hypertensive or hypotensive he disease of extreme degree.

Warnings: Administer cautiously to patients who have previou exhibited a hypersensitivity reaction (e.g., blood dyscrasias, ja dice) to phenothiazines. Phenothiazines are capable of potentiat central nervous system depressants (e.g., anesthetics, opiates, cohol, etc.) as well as atropine and phosphorus insecticides. D ing pregnancy, administer only when the potential benefits exce the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukope and/or agranulocytosis and convulsive seizures. In epileptic tients, anticonvulsant medication should also be maintained. F mentary retinopathy may be avoided by remaining within the r ommended limits of dosage. Administer cautiously to patients p ticipating in activities requiring complete mental alertness (e. driving), and increase dosage gradually. Orthostatic hypotens is more common in females than in males. Do not use epinephr in treating drug-induced hypotension since phenothiazines may duce a reversed epinephrine effect on occasion. Daily doses excess of 300 mg. should be used only in severe neuropsychiat conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especia with large doses, early in treatment; infrequently, pseudopark sonism and other extrapyramidal symptoms; nocturnal confusio hyperactivity, lethargy, psychotic reactions, restlessness, and hea ache. *Autonomic Nervous System*—Dryness of mouth, blurred sion, constipation, nausea, vomiting, diarrhea, nasal stuffine and pallor. *Endocrine System*—Galactorrhea, breast engorgeme amenorrhea, inhibition of ejaculation, and peripheral edema. *Ski* Dermatitis and skin eruptions of the urticarial type, photosen tivity. *Cardiovascular System*—ECG changes (see *Cardiovascular fects* below). *Other*—A single case described as parotid swelling. The following reactions have occurred with phenothiazines a should be considered: *Autonomic Reactions*—Miosis, obstipatio anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfol tive dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulo tosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplas anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal eden angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, bilia stasis. *Cardiovascular Effects*—Changes in terminal portion of ele trocardiogram, including prolongation of Q-T interval, loweri and inversion of T-wave, and appearance of a wave tentative identified as a bifid T or a U wave have been observed with pher thiazines, including Mellaril (thioridazine); these appear to be versible and due to altered repolarization, not myocardial damag While there is no evidence of a causal relationship between the changes and significant disturbance of cardiac rhythm, seve sudden and unexpected deaths apparently due to cardiac arre have occurred in patients showing characteristic electrocard graphic changes while taking the drug. While proposed, perio electrocardiograms are not regarded as predictive. Hypotensio rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akat sia, agitation, motor restlessness, dystonic reactions, trism torticollis, opisthotonus, oculogyric crises, tremor, muscular ri ity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent sometimes irreversible tardive dyskinesia, characterized by rh mical involuntary movements of the tongue, face, mouth, or (e.g., protrusion of tongue, puffing of cheeks, puckering of mo chewing movements) and sometimes of extremities may occu long-term therapy or after discontinuation of therapy, the ris ing greater in elderly patients on high-dose therapy, espe females; if symptoms appear, discontinue all antipsychotic ag Syndrome may be masked if treatment is reinstituted, dosa increased, or antipsychotic agent is switched. Fine verm movements of tongue may be an early sign, and syndrom not develop if medication is stopped at that time. *Endocri turbances*—Menstrual irregularities, altered libido, gynecor lactation, weight gain, edema, false positive pregnancy *Urinary Disturbances*—Retention, incontinence. *Others*—H rexia; behavioral effects suggestive of a paradoxical reac cluding excitement, bizarre dreams, aggravation of psycho toxic confusional states; following long-term treatment, a skin-eye syndrome marked by progressive pigmentation or conjunctiva and/or accompanied by discoloration exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

73-824

SANDOZ PHARMACEUTICALS, EAST HANOVER, NEW JERS

THE AMERICAN JOURNAL OF PSYCHIATRY

Community Mental Health Services in Britain

BY DOUGLAS BENNETT, M.D., D.P.M.

Although the practice of psychiatry was similar in the United States and Britain during the last century, since then their paths have diverged, especially since the Second World War and the institution in Britain of the National Health Service. The major postwar development in Britain has been in social psychiatry, with particular reference to hospitalized psychotic patients. More recently, plans have been made to close mental hospitals and shift the locus of inpatient care to the general hospital. Projections have been made to provide services on a sector basis, in which teams of psychiatrists, nurses, and social workers serve population groups of 60,000 each and provide outpatient and transitional facilities as well as inpatient care. The author compares the different approaches in the United States and Britain and notes that, while neither can provide an ideal service, both can learn much from the differences.

WHEN WE IN BRITAIN use the word "community" in a mental health context, we are referring to care given outside the mental hospital in the mythical world of well people (1). We may include, too, the prevention of hospital admission and the idea of district or sectorized care. In the United States, "community" in a mental health context seems to have more to do with localism and the idea that services are better managed at the community level. I have heard it suggested that this view, which may have been inherited from Utopian thinkers of the 18th century, now reflects a dislike of the direct provision of services by the state (2). Whether that is so or not, it does emphasize the fact that since "community mental health" is deeply rooted in the history and the beliefs of our respective societies, it also has different meanings for both of us.

In trying to explain something of community mental health in my country I must try to make these differences clear. But I shall also try to avoid dangerous comparisons, for in the worldly wisdom of Samuel Johnson, "by exciting emulation and comparisons of superiority, you lay the foundations of lasting mischief; you make brothers and sisters hate each other." That I do not want to do.

Read as a special lecture at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Bennett is Psychiatrist, the Bethlem Royal Hospital and the Maudsley Hospital, Denmark Hill, London SE5 8AZ, England.

OUR INHERITANCE

In the 19th century the practice and problems of psychiatry were very similar in our two countries. We both had our reformers. You had Dorothea Dix, who believed in the value of the mental hospital. We had John Conolly, who, by abolishing physical restraint, did much to improve our care of the mentally ill. Many before him had thought that the physical restraint of the mentally disordered could and should be reduced, but no one thought that it was possible to abolish it completely (3). Conolly's action in doing this led to great controversy, for he was eager that the mentally ill should be treated with the same good intentions as doctors treated the physically sick. Whatever we think now about equating mental disorder with illness, at that time it did much to better the social position and to increase the freedom of the mentally sick. So it is not surprising that Conolly also believed that mental disorders should be treated, whenever possible, outside the mental hospital. It took some time for his ideas to be accepted and their full impact had to wait on later social changes; I cannot tell the whole story.

In the latter part of the last century and in the first half of this one, matters moved forward rather sedately. Then the shared dangers and experiences of the Second World War drew people of all classes in our society closer together. By the end of the war it was accepted that it was the proper function of government to ward off stress and strain not only among the poor but among all classes of society. Sir William Beveridge's plan to combat the evils of want, disease, ignorance, squalor, and idleness was implemented in a series of enactments that led to what we now call the Welfare State. In an attempt to deal with

disease, the National Health Service was established as one limb of this body.

Some see our Welfare State as helping the disadvantaged to make good; others see it as undermining people's self-sufficiency by state handouts. But whatever one's opinion of its effect on the wider society, its egalitarian philosophy of "bread for all before cake for anybody" has had a very considerable influence on the provision of services for the mentally ill. In the National Health Service, which came into being in 1948, psychiatrists (like other doctors) were salaried. They received the same pay as the surgeons and internists wherever they worked. The service brought all the hospitals, whether general or mental, formerly managed by local bodies, under the same regional and national direction. As soon as these hospitals were administered side by side the difference in the quality of care given to the mentally disordered and the physically ill was shown up in bold relief. Also, the difference in the terms under which people were eligible for treatment was so great that quite soon the whole question of legal commitment was referred to a Royal Commission (4).

Their enquiry and recommendations led to a new Mental Health Act, which was passed by Parliament in 1959. This act made it possible for the mentally ill person who could accept the role of patient to be admitted to a hospital without the formality of commitment. Committal, when needed, was no longer a quasijudicial process. Instead, two doctors, one a qualified psychiatrist, had to explain why care or treatment was needed and why the individual could not be treated in the role of a voluntary patient. Today less than 17 percent of admissions to our psychiatric hospitals are compulsorily committed, and only six percent of hospital residents are detained in this way. The Royal Commission also stated the view that greater efforts should be made to avoid hospital admissions. Its report gave official recognition to those community psychiatric services which had already been developed up and down the country and encouraged a further use of out-of-hospital care.

PRESENT THINKING

In the words of one American visitor: "The major postwar development in British psychiatry has been in social psychiatry, with particular reference to psychotic patients in hospital. By contrast, in the United States, a major development has been in so-called dynamic psychiatry, with particular reference to ambulatory neurotic patients" (5). Knight Aldrich thought, quite rightly, that our pattern of care was a direct outcome of the National Health Service, an origin that has influenced its subsequent development.

Since both the mental hospitals and the general hospitals are managed by the same regional hospital boards, the planning of community psychiatry services has been undertaken in a medical context. This was Ministry of Health policy, and in 1960 its Chief Medical Officer, Sir George Godber, urged that "if the opportunity for bringing psychiatry fully into the general pattern of medicine which now presents itself is grasped, the new attitudes created both within the profession and in the public mind, will do more for mental health than any other single measure" (6).

At that time the Ministry of Health was encouraging the development of psychiatric outpatient, day-patient, and inpatient services in general hospitals but still thought that a substantial part of hospital psychiatric work would have to be undertaken in the traditional mental hospital. More recently the department has decided that improvements in treatment and care allow us to replace the large separate mental hospitals with a service based in the general hospitals. This is a dramatic change in policy. In such a service the general hospital psychiatric unit will combine with the other two parts of our three-part health service—that is, the family doctor and public health sectors—to provide comprehensive psychiatric care to a defined district. The Department of Health intends that these facilities should be used as flexibly as possible and that emphasis should be given to rehabilitation and to the preservation of continuity in the patient's personal relationships and his contacts with his local community (7). There are hopes that these three parts of the medical services can plan more effective comprehensive care when, next year, they are merged and administered by area health boards.

This is the rhetoric; you may wonder by how much it is separated from reality. There is of course a gap, but it may be narrowing rather than widening. It should be filled in part by a newcomer to our services: the social services department of the local authority. This new body grew out of the appreciation by the social workers and government that the existing social services were responsible only for certain types of social problems and the difficulties of particular age groups (8). It was felt that human needs could not be categorized in such an arbitrary fashion in spite of the realization that medical care, education, and housing all have social components. So it was decided that social workers should give up such former specialisms as mental health, child care, and welfare and merge these into one department providing a unified family service. Social workers accepted this, integrated their professional associations and their differing trainings, and, when sanctioned by the Social Services Act of 1971, took charge of their own departments in the local authorities.

While some people regret the disappearance of the former mental health and psychiatric social workers, the new departments provide a useful social counterpoise to our medically oriented psychiatric services. But the departments are young and are preoccupied with their own internal problems, so it will be some time before the social workers can make their full contribution to community mental health. Meanwhile, many psychiatrists say that the removal of social workers from the medical orbit has made effective cooperation impossible (9). Since there are plenty of examples of fruitful cooperation between psychiatrists and social service departments, these remarks only show that many doctors do not know how

to work for and with social workers. The doctor's outlook has some importance, for the next stage of our planned development is the closing of the mental hospital, and that requires teams of social workers, psychiatrists, and others to work together to meet the needs of a specified population. The administrative discontinuity between health and social service departments must make teamwork difficult, although with the right attitudes this could be overcome.

CLOSING THE MENTAL HOSPITAL

The arguments for closing the mental hospital have never been very clearly stated. In the 1950s community care was seen as preventing admission, or, failing that, securing the patients' early discharge from the hospital. Such a policy was community minded only in the sense that it was anti-institutional. Not surprisingly, a comparative evaluation of three dissimilar services, including a community service with a worldwide reputation, did not confirm the value of this limited type of community care (10). In spite of this as well as great and well-known achievements of some of our mental hospitals, they have remained the villain of the piece in community mental health. Many people feel that the continuing accumulation of patients in these ghettos has cast a shadow over all our services and mocks our therapeutic pretensions.

Some argue that we cannot get rid of our mental hospitals before we have adequate alternative services. Certainly we have an increasingly clear idea, in numerical and other terms, of the alternatives that are needed (11). Others believe that alternative services will not be provided as long as the mental hospital remains as a convenient way to dispose of difficult problems.

We know that as long as we have mental hospitals we are unlikely to prevent admission to them. Hopes that this would happen have always overlooked one important aspect of psychiatric care: the desire of mental health professionals to get rid of undesirable patients. This distinction is almost unique to psychiatry and reflects an intolerance rooted in the inability of doctors and others to deal with their own feelings, whether of hostility, anxiety, or a sense of failure (12).

There are many ways of tackling the problem, but the fundamental solution is that professional staff members have to give up the right to refuse referrals and the right to refuse to refer people to other services (13). In practice, undesirable patients are referred in only one direction, whose final destination is the mental hospital. Elimination of the mental hospital does not solve the problem entirely, for with or without the mental hospital, both doctors and social workers may refer unwanted patients to colleagues with lower status or less training (14). But the taking apart of mental hospitals will force the staff to look for other solutions and to rethink the real nature of psychiatric care.

Part of the hospital dismantling happens naturally, for in our country, as in yours, there is a steady attrition of long-stay hospital patients by discharge or death and only a slow accumulation of new chronic patients (15). Simultaneously, new patients have to be diverted to other services and in particular to the district general hospital. There are dangers for the mental hospital. The knowledge that the hospital is going to close can lead to a sharp decline in staff morale, which results in a deterioration in standards of care. To avoid this it is proposed that the mental hospital's catchment area should be split into geographical districts of 60,000 population. Then each district will be served by a team made up of district general hospital and mental hospital staff members and social workers from the new departments. The beds and day places in both the mental hospital and the district general hospital will be divided, so that each team has day places and beds in both situations (7). When eventually the new general hospital psychiatric department can provide all the necessary services, the few patients remaining in the mental hospital will be transferred to another mental hospital whose closure program is less advanced. This is an ambitious plan and progress must be slow, for evolution, not revolution, is the aim. Even so, reaction—especially from doctors—has been quite brisk.

DOUBTS AND DIFFICULTIES

In such a situation reality and rhetoric tend to drift apart. I have already introduced you to what Titmuss (16) called "that exotic hothouse climbing rose, 'the welfare state,' with its lovely hues of tender pink and blushing red, rampant and rampaging all over the place, often preventing people from 'standing on their own feet,' in their own gardens." He went on to wonder whether the everlasting cottage garden trailer "community care" did or did not conjure up a sense of warmth and human kindness essentially personal and comforting. It may have done so, but it has conjured up controversy and criticism too. Doctors hold strongly partisan views for or against community psychiatry; these have been thought to have a distinctly American flavor (17). But these views are equally evident in Britain. I suspect that the flavor is neither British nor American, but medical.

The public, on the other hand, seems to welcome the community approach. They have always cared for the mentally ill, and it is only in quite recent years that they have begun to trust the mental hospitals to do this for them. Of course the mentally ill were not always well cared for outside the hospital. However, a national opinion poll in 1971 showed strong public support for undertaking the care of the mentally ill in the community (18). Six out of every ten people interviewed thought that the mentally ill should be encouraged to lead a normal life. At the same time, the public openly discusses and criticizes conditions in mental hospitals that previously were not mentioned in the press (19). Meanwhile some psychiatrists, seemingly forgetful of recent scandals, revive nostalgic memories of mental hospital gardens with their flowers and green lawns and speak of them as a sanctuary for patients (20).

While the debate continues, community psychiatry has

not provided a ready banner for those in our islands demanding social change or marching in a radical activist cause (21).

More substantial doubts have been expressed about the government's plans. The statistical projections of change in bed needs and the experiences of a few community services are critically questioned, for it is on these rather doubtful data that the plan seems to be based (22–24). The success of the plan in its present form depends on certain assumptions "which have not yet been tested; that very few patients will in future become severely handicapped psychiatrically, that those who do so will either not require residential care or can be looked after adequately by the social services and that the disadvantages apparently inherent in the mental hospital system will not be inherent in any system which replaces it" (11).

It does seem that the number of hospital beds allowed in the plan may be too low. It seems, too, that little or no thought has been given to the needs of that small number of patients, mostly with schizophrenia or organic mental syndromes, who still become handicapped in spite of all we do. Obviously there will be difficulties in establishing effective cooperation between psychiatric units in the district general hospitals and the new social service departments that, between them, will have to provide the shelter and the rehabilitation services that were the mental hospitals' special contribution to the care of chronic patients. There are doubts, too, not only about how they will cooperate, but how each will meet its own responsibility. Some wonder whether the social service departments can provide these facilities, or whether they can provide them in time.

It is important that the provision should be kept in phase with the transfer of medical services from the mental hospital to the district general hospital. Doctors doubt whether the general hospital, for its part, can cope with patients whose problems are difficult or chronic. It is assumed that because general hospitals have dealt only with the less severely ill, that is all they can do. This is not so, but of course they will have to change their ways of functioning and they will need support from other services as well as accommodation in hostels, boarding houses, and day centers for those with permanent handicaps.

THE PRESENT SITUATION

It is unlikely that the scheme in its present form will meet all these needs, and evaluation of the services is essential. There is ongoing evaluation of some developing services, and other evaluations are projected (11). The findings, taken together with the experience of clinicians, should lead to later modifications of the government's policy.

It will be clear from this account that our present mental health services are still largely centered on the hospital and the psychiatrist. Our major aims are the prevention of chronic patienthood and the closing of the mental hospital, rather than primary prevention, consultation, and crisis intervention. This outlook is in part an expression of our pragmatism and in part determined by the history and the logic of our situation. Having recognized that with the means at our disposal we could not prevent mental illness or prevent some patients from developing very severe handicaps, we decided that we would deal with what was within reach not only of our understanding but of our resources. In time we shall do more for mental health than for mental illness and be more interested in communities than hospitals. At present, manpower is limited and so are budgets; this has an effect on what is done.

There will be three psychiatrists (and only one of those a senior) for the population of 60,000 persons that is the basic unit in our planning. This population will yield about 500 patients who are in our care at any one time while approximately another 500 people, 215 of them inpatients and about 265 outpatients, will come into care each year (25). They will be supported by hospital and public health nurses and by social workers. There will also be about 24 family doctors in the area. These doctors, however, cannot give psychiatrists much help, for in our health service family doctors are already seeing the bulk of the patients with socio-emotional problems (26). These patients suffer mostly from minor affective illnesses that are associated with various forms of social difficulty (27). The family doctor's interest in his patients' socio-emotional difficulties and his capacity to deal with them are closely related, whether by cause or effect, to the size of his practice (28). He refers those with the more difficult and time-consuming problems to the psychiatric outpatient departments and is often reluctant to support them after they are discharged from the hospital. Many solutions have been proposed: these include giving family doctors more education and understanding of socio-emotional problems and reorganizing their practices on a group basis with social workers attached. While matters are slowly changing, we know that many family doctors are still not keen on working with social workers (29).

When people suggest, as many do, that we cannot meet the requirements of a community-based mental health service with our present resources, they overlook the fact that the redeployment of these resources, if it does not improve the situation greatly, is unlikely to worsen it. Staff morale can have a considerable effect, and it seems clear that the morale of mental health personnel is higher when they work outside mental hospitals. At the same time we are uneasily aware of the increasing demand on services that are separate from mental hospitals. Also, the scope of psychiatry's responsibilities is more broadly defined. It is no longer enough to provide for the needs of the mentally ill, the mentally retarded, and disturbed children. We have to provide more service for mentally disturbed offenders, mentally infirm old people, alcoholics, drug addicts, and those who attempt suicide and self-poisoning.

It seems obvious that if we are to meet all these new demands, our tasks and responsibilities will have to be reallocated. A service based on sectorized care has certain advantages in this respect, for the sector defines the responsibility of psychiatrists and others who have to

share the patients' care. It forms a base for cooperation with families and with a range of services providing social help whose very existence is undreamed of by many hospital psychiatrists. Even today, district services have provided some working or living environments for those persons who are severely handicapped by mental illness and who lack family support. There are not enough, but they are there and provision for them is growing. Of course, sectorization does not ensure that the psychiatric and social services will cooperate. So much has been said and written about continuity of care, cooperation, coordination, and teamwork that the words have all but lost their meaning. They do not tell us how to work or what to do. They provide no basis for teaching psychiatrists. Many still think that community psychiatry is nothing more than keeping the patient out of the mental hospital, giving first aid care, talking to a social worker, or sending the patient to a day hospital. Some believe that community services allow psychiatrists to escape the painful business of facing up to the patient's problems. Nothing could be farther from the truth.

THEORY AND RESEARCH

There is much more to community mental health services than their administrative structure. It takes more than goodwill, common sense, and enthusiasm to provide effective help. Meyer Gross said many years ago that "advances in mental health are not made by administrative dodges or by giving new names to old problems." Some old problems are always with us, and none is more teasing than the balance of advantage and disadvantage between treatment in the hospital or in the community. There is no right or wrong solution, only better or worse decisions for certain people, at certain times, and in certain circumstances. Yet we cannot learn how to make those decisions, modify our services, or teach others unless we have a sound basis in theory and research. While community psychiatry must have a practical base in a sectorized service, its theoretical foundation is in social psychiatry. Sabshin brought these two facets together when he said that community psychiatry uses social psychiatry's techniques, theories, and methods, as well as those of the other behavioral sciences to meet the mental health needs of a defined population over a significant period of time (17).

It is one of the little-known strengths of the British community mental health service that we have a small but influential group of research workers in social psychiatry. Their work grew out of the Medical Research Council's Social Psychiatry Research Unit, which was founded by Sir Aubrey Lewis in 1948—the same year that the National Health Service was established. Their research and their names are well known (30). They have influenced plans and policies and have provided guidelines in matters of patient management, rehabilitation, and social treatment.

It is still difficult to attract first-class clinicians from the hospital to community mental health. The view that they will come to us only when they see that community mental health has scientific substance is reflected in the remarks made by a young American lecturer working with us. "It is this emphasis on the scientific validation of delivery systems and treatment techniques which lends respectability to the movement and makes community psychiatry a proper pursuit within the university" (31). But trainees must not learn only about community and social psychiatry. They have to learn to be community psychiatrists. Training in community psychiatry requires that the student work in a situation where the patient and his family remain the staff's responsibility over a considerable period of time. The community psychiatrist does not learn by working in private with highly selected patients who are "his" alone. He has to learn through the sobering experience of sharing with a team the care of those who may be poor, unintelligent, or poorly motivated or who may fail to improve with treatment (32). The knowledge that there is no escape from this responsibility and that the team's failure to help the patient involves them in his long-term care concentrates the mind wonderfully and leads to more ingenious and useful solutions. The resulting growth of staff confidence and competence is another factor that is rarely taken into account yet is crucial to the future function of our community mental health services.

In Britain, at least, community psychiatry is not a soft option, offering "less painful jobs at higher salaries, with high sounding titles, plus opportunities for community contact, the novelty of newspaper interviews and speech making" (33). I doubt whether it is like that in America either. For wherever we work, our methods differ and our failings and our excellences differ. Neither of our two countries can provide the ideal service. One hopes that we can learn something from our differences.

REFERENCES

1. Vickers G: Community medicine. Lancet 1:944–947, 1967
2. Cumming E: Community psychiatry in a divided labor, in Social Psychiatry. Edited by Zubin J, Freyhan F. New York, Grune & Stratton, 1968, pp 100–113
3. Bennett DH: One hundred years after John Conolly. Proc R Soc Med 60:89–92, 1967
4. Department of Health and Social Security: Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, Command 169. London, Her Majesty's Stationery Office, 1957
5. Aldrich CK: Psychiatry consultation in general practice. Lancet 1: 805–808, 1965
6. Department of Health and Social Security: Annual Report of Chief Medical Officer, Command 1550. London, Her Majesty's Stationery Office, 1960
7. Department of Health and Social Security: Hospital Services for the Mentally Ill, Hospital Memorandum 97. London, Her Majesty's Stationery Office, 1971
8. Department of Health and Social Security: Report of the Committee on Local Authority and Allied Personal Social Services, Command 3703. London, Her Majesty's Stationery Office, 1968
9. The Mental Health Service After Unification, Report of the Tripartite Committee of Royal College of Psychiatrists, Society of Medical Officers of Health, and the British Medical Association. London, British Medical Association, 1972
10. Brown GW, Bone M, Dalison B, et al: Schizophrenia and Social Care, Maudsley Monograph 17. London, Oxford University Press, 1966

11. Wing JK, Hailey AM (eds): Evaluating a Community Psychiatric Service: The Camberwell Register 1964–71. London, Oxford University Press, 1972
12. Hill D: Psychiatry in Medicine: Retrospect and Prospect. London, Nuffield Provincial Hospitals Trust, 1969
13. Cumming E: Three issues affecting partnerships among mental health agencies. Hosp Community Psychiatry 22:33–37, 1971
14. Rudolph C, Cumming J: Where are additional psychiatric services most needed? Social Work 7:15–20, 1962
15. Hailey AM: Longstay psychiatric inpatients: a study based on the Camberwell Register. Psychol Med 1:128–142, 1971
16. Titmuss RM: Community care: fact or fiction? in Trends in the Mental Health Service. Edited by Freeman H, Farndale J. London, Pergamon Press, 1961, pp 293–318
17. Sabshin M: Theoretical models in community and social psychiatry, in Community Psychiatry. Edited by Roberts LM, Halleck SL, Loeb MB. Madison, University of Wisconsin Press, 1966, pp 15–30
18. The muddled approach to sick minds. London, Sunday Times, Oct 11, 1971, p 7
19. Department of Health and Social Security: Committee of Inquiry Into Conditions at Whittingham Hospital, Command 4861. London, Her Majesty's Stationery Office, 1972
20. Back to the "Bin"? Lancet 1:527–528, 1973
21. Goldberg D: The scope and limits of community psychiatry. Modern Problems of Pharmacopsychiatry 6:5–25, 1971
22. Baker AA: Psychiatric illness in a district general hospital. Lancet 1:1090–1092, 1969
23. Oldham AJ: Community psychiatry in London: a three-year analysis. Br J Psychiatry 115:465–474, 1969
24. Tooth GC, Brooke EM: Trends in the mental hospital population and their effect on future planning. Lancet 1:710–713, 1961
25. Birley JLT: The ghost in the machine, in Policy for Action. Edited by Cawley R, McLachlan G. London, Oxford University Press, 1973, pp 103–109
26. Shepherd M, Cooper B, Brown AC, et al: Psychiatric Illness in General Practice. London, Oxford University Press, 1966
27. Cooper B: Social correlates of psychiatric illness in the community, in Approaches to Action: A Symposium on Services for the Mentally Ill and Handicapped. Edited by McLachlan G. London, Oxford University Press, 1972, pp 65–70
28. Mechanic D: Practice orientation among general medical practitioners in England and Wales. Med Care 8:15–25, 1970
29. Harwin BG, Cooper N, Eastwood MR, et al: Prospects for social work in general practice. Lancet 2:559–561, 1970
30. Shepherd M, Davis DL (eds): Studies in Psychiatry. London, Oxford University Press, 1968
31. Cavanaugh JL: Rehabilitation and Chronic Mental Illness, British Models. Philadelphia, 1971 (processed)
32. Mesnikoff AM: Urban psychiatry: effects on the psychiatric institute, in Urban Challenges to Psychiatry. Edited by Kolb LC, Bernard VW, Dohrenwend BP. Boston, Little, Brown and Co, 1969, pp 221–225
33. Kubie LS: Pitfalls of community psychiatry. Arch Gen Psychiatry 18:257–266, 1968

Questions of the Month

Directions: Each of the incomplete statements below is followed by four or five completions. Select the *one* that is BEST in each case.

Question 1 The sudden and repeated cessation of a person's train of thought or speech in the middle of a sentence (blocking) is most characteristic of
(A) children in latency (7–11 years)
(B) psychotically depressed patients
(C) schizophrenic patients
(D) patients with Korsakov's disease
(E) patients with manic-depressive psychosis

Question 2 Myoclonic jerks or generalized convulsions with paroxysmal activity on the electroencephalogram may be observed prior to drug withdrawal when high daily dose levels have been attained during chronic intoxication with
(A) heroin
(B) methadone
(C) cocaine
(D) pentobarbitol (Nembutal)
(E) meperidine (Demerol)

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 1081. The references for the questions are supplied on page 1117.)

Epidemiological Differences Between White and Nonwhite Suicide Attempters

BY ANDREAS M. PEDERSON, PH.D., GEORGE A. AWAD, M.D., AND ALAN R. KINDLER, M.B.B.S.

Using the Monroe County (N.Y.) Psychiatric Case Register, a stable data source, the authors attempted to determine differences between white and nonwhite suicide attempters, to identify the factors that are associated with self-destructive behavior in both groups, and to determine the subsequent mortality rate among suicide attempters. They found a number of differences between whites and nonwhites and conclude that the motivation for suicide, the techniques used to treat attempts, and the degree of risk of further psychiatric difficulty may be different for the two groups.

DURING THE PAST SEVERAL YEARS an increasing amount of research on suicide and suicide attempts has been conducted (1). Many of these studies have focused on the relationship between suicide and suicide attempts (2, 3), while others have focused on the clinical course and outcome of persons who have attempted suicide (4). A number of these studies have outlined basic demographic characteristics and some psychological factors associated with people who attempt suicide; however, the epidemiological study of suicide attempts is one major area of investigation that has only recently begun to be examined systematically (5).

Although our knowledge about suicide attempts has increased considerably, a number of questions about the factors associated with persons who attempt suicide remain unanswered. Part of this is due to the unreliable data collection systems that are used to record attempted and accomplished suicides in most communities. Another problem is that many of the previous studies on suicide attempts have used relatively small or highly selected samples. For example, most have included only those suicide attempts which have been identified by admission to general hospitals or by reports to the police. Because of the variability in data collection systems and because different sample selection procedures have been used, conclusions based on comparisons of these studies are of limited validity.

Further, while there is evidence to suggest that patterns of suicide attempts and characteristics of attempters are different in white and nonwhite populations (6, 7), little work has been done to investigate these differences in a systematic manner. These differences could produce considerable variance in studies of attempted suicides, particularly with certain types of sample selection procedures. More importantly, however, if race is not examined as a separate factor, true differences between white and nonwhite groups, which may indeed be helpful in understanding attempted suicides, may go unnoticed.

We attempt in this paper to clarify some of the problems found in previous research through an epidemiological study of suicide attempts in a relatively stable population over a four-year period. By examining the differences between white and nonwhite suicide attempters and outlining the demographic characteristics of suicide attempters, we hope to identify the characteristics associated with high-risk groups in terms of self-destructive behavior and to provide some insight into the underlying motivations for a wide range of self-destructive and potentially suicidal behavior. In addition, we will investigate the number of deaths among these suicide attempters in a five-year follow-up period, looking particularly at those deaths attributed to suicide.

METHOD

The sample consists of all consecutive suicide attempters treated in the emergency department of Strong Memorial Hospital during the years 1964 through 1967. Strong Memorial Hospital, the teaching hospital of the University of Rochester School of Medicine and Dentistry, is the largest general hospital in Monroe County, New York. During this study period the average yearly number of patient contacts in the emergency department was about 55,000. Every suicide attempter or suspected attempter who was treated in the emergency department was seen by a psychiatric resident before discharge. This contact was then reported to the Monroe County Psychiatric Case Register.

The Monroe County Psychiatric Case Register was used to identify the characteristics of the suicide attempters seen during the study period. The register was started on January 1, 1960, and nearly every psychiatric contact made in Monroe County has been reported to it since

At the time this work was done, the authors were with the Department of Psychiatry, University of Rochester School of Medicine and Dentistry, 260 Crittenden Blvd., Rochester, N.Y. 14642, where Dr. Pederson is Assistant Professor of Psychiatry and Psychology and Drs. Awad and Kindler were residents in psychiatry. Dr. Awad is now Associate, the Clarke Institute of Psychiatry and the Psychiatric Service of the Provincial Court (Family Division), Toronto, Ont., Canada, and Dr. Kindler is Associate, Department of Psychiatry, University of Toronto.

The Monroe County Psychiatric Case Register was supported from 1960 to 1969 by Public Health Service grant MH-00381 from the National Institute of Mental Health and is currently supported by the New York State Department of Mental Hygiene, the Monroe County (New York) Board of Mental Health, and the University of Rochester. This work was supported in part by these funds and by Public Health Service grant MH-08469 from NIMH.

then (8). In addition to basic demographic data about each patient, diagnoses, including the designation "suicide attempt," are recorded for each psychiatric contact, along with an indication of the presence or absence of previous psychiatric care. The register also records the deaths and their causes for every person who has been reported. This procedure creates not only a continuing psychiatric register but also a continuing and updated death register. In the register, race is categorized as white or nonwhite. The white group includes all Caucasians and most of the Puerto Rican and American Indian ethnic groups, while the nonwhite group is composed almost exclusively of people of Negroid ancestry. The socioeconomic level of a person who is reported to the register is defined by the census tract in which he lives. Each census tract in Monroe County has been classified into one of five groups (from I at the highest to V at the lowest) on the basis of a composite index of social and economic factors. These factors and the method of classification have been described elsewhere (9).

Out of 219,233 emergency room contacts at Strong Memorial Hospital during the study period (1964 through 1967), 1,345 persons were seen as the result of a suicide attempt. While there were five other hospitals with emergency services in the Rochester-Monroe County area during the study period, Strong Memorial Hospital had nearly twice as many emergency room contacts per year as any other, and it was the only hospital that had a psychiatric facility in the emergency department. Because of its range of services and psychiatric facilities, most suicide attempts in the county area were referred to Strong Memorial Hospital. Examination of the emergency log from another large general hospital, which ranked third in the number (121, 266) of total emergency room contacts during the study period, revealed that only 125 suicide attempts had been treated in its emergency department.

Unlike samples used in many other studies of suicide attempts, this sample has the advantage of including all consecutive suicide attempts seen in an emergency department; it consequently provides a wider range of suicidal behaviors, from the mild suicide gesture to the relatively serious attempt. Also, because most of the suicide attempts in the county were treated at Strong Memorial Hospital, the sample is fairly representative of all suicide attempts made throughout the county.

TABLE 2
*Age-Specific Average Annual Rates for Suicide Attempts by Race and Sex**

Age Group	White		Nonwhite	
	Male	Female	Male	Female
0–14	1	2	10	5
15–24	90	238	153	803
25–44	49	129	67	436
45–64	21	44	0	87
65 and over	18	13	0	62
Crude rate	29.91	74.34	48.82	266.08

*Rate is the number of attempts per 100,000 based on the 1960 census of Monroe County.

RESULTS

Of the 1,345 suicide attempts recorded at Strong Memorial Hospital during the study period, 335 (25 percent) were made in 1964, 347 (26 percent) in 1965, 313 (23 percent) in 1966, and 350 (26 percent) in 1967; the yearly average number of suicide attempts was 336. The total number of completed suicides in Monroe County for the four-year period (obtained from county health statistics) was 244, an average of 61 per year. The ratio of suicide attempts treated in our emergency department to completed suicides for the four-year period was 5.5:1. These figures represent an annual rate for suicide attempts treated at Strong Memorial Hospital's emergency department of 57.30 per 100,000 and a county suicide rate of 10.4 per 100,000 for each year of the study period.

Table 1 presents the total group of suicide attempters by age, race, and sex. Eighty-eight percent (1,186) of the total sample were white and 12 percent (159) were nonwhite. Women accounted for 74 percent (1,000) of the total. Eighty-four percent (1,128) fell within the group aged

TABLE 1
*Suicide Attempts by Age, Race, and Sex**

Age Group	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0–14	5	1	7	1	2	9	1	1	15	1
15–24	110	34	327	38	10	45	63	46	510	38
25–44	141	44	400	46	10	45	67	49	618	46
45–64	48	15	111	13	0	0	5	4	164	12
65 and over	19	6	18	2	0	0	1	1	38	3
Total	323		863		22		137		1,345	

*The distribution by race and sex for the 1960 census of Monroe County was: white males = 46 percent, white females = 50 percent, nonwhite males = 2 percent, and nonwhite females = 2 percent.

TABLE 3
Suicide Attempts by Socioeconomic Level, Race, and Sex

Socioeconomic Level	Percentage of Total County Population	White				Nonwhite				Total	
		Male		Female		Male		Female			
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
I	12	21	7	80	9	0	0	1	1	102	8
II	26	67	21	209	24	2	9	2	1	280	21
III	43	133	41	359	42	1	5	17	12	510	38
IV	12	74	23	168	19	8	36	53	39	303	23
V	5	28	9	45	5	11	50	62	45	146	11
Unknown		0	0	2	1	0	0	2	1	4	<1
Total		323		863		22		137		1,345	

15 to 44. In the white group, 73 percent (863) were women and 27 percent (323) were men, a ratio of approximately 3:1. However, in the nonwhite group, 86 percent (137) were women and only 14 percent (22) were men, a ratio of 6:1, which is quite different from that of the white group. Age also differentiated the white from the nonwhite group. While 82 percent (978) of the whites were between 15 and 44 years old, 94 percent (150) of the nonwhites were in that age range. There was no nonwhite man older than 45 in the study group.

Table 2 presents the age-specific average annual rates for suicide attempts by race and sex. The combined rate for whites was 52.91 and that for nonwhites was 159.57; the overall crude rate was 57.30. In every age group where nonwhite suicide attempts were recorded, the rates were higher for the nonwhites than for the whites. This is especially obvious for the nonwhite women in the groups aged 15 to 44. Even when the overall rates were adjusted for age, the differences remained; the age-adjusted rate for nonwhite women (268.12) was nearly four times that of white women (74.19), and similarly the rate for nonwhite men (44.87) was approximately 1.5 times the rate for white men (29.68). In some cases, the reported rates are based on relatively small frequencies, since only a few suicide attempts were recorded in some age groups and the total number of nonwhite suicide attempts was relatively small in terms of overall frequency.

Table 3 presents the socioeconomic levels of the suicide attempters in the sample. As can be seen, levels IV and V were overrepresented. These two levels accounted for 33 percent (449) of the attempters but represented only 19 percent of the total county population. Although socioeconomic levels I and II accounted for 38 percent of the total county population, only 28 percent (382) of the sample was from these two levels. In the white group, persons from socioeconomic levels IV and V represented 27 percent (315) of the attempts, while in the nonwhite group 84 percent (134) were from these two levels. In contrast, socioeconomic levels I and II accounted for 32 percent (377) of the white attempters but only three percent (five) of the nonwhites.

The relationship of marital status, race, and sex of the suicide attempters is presented in table 4. Examination of the marital status in terms of race and sex revealed that only 38 percent (61) of the nonwhite suicide attempters were married compared with 50 percent (594) of the white group. Among nonwhite men, 55 percent (12) of the suicide attempters were single and among the nonwhite women 28 percent (39) were separated. These two rates are in marked contrast to those for the white group and appear to account in large part for the different rates of married people in the white and nonwhite groups.

The relationship of psychiatric diagnosis given at the time of the suicide attempt to race and sex is presented in

TABLE 4
Suicide Attempts by Marital Status, Race, and Sex

Marital Status	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Single	121	37	269	31	12	55	40	29	442	33
Married	155	48	439	51	8	36	53	39	655	49
Separated	25	8	79	9	1	5	39	28	144	11
Divorced	14	4	60	7	1	5	4	3	79	6
Widowed	8	2	16	2	0	0	1	1	25	2
Total	323		863		22		137		1,345	

TABLE 5
Suicide Attempts by Diagnosis, Race, and Sex

Diagnosis	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Schizophrenia	48	15	80	9	1	5	8	6	137	10
Affective psychosis	21	7	29	3	1	5	3	2	54	4
Chronic brain syndrome	10	3	8	1	0	0	3	2	21	2
Neurosis	86	27	250	29	8	36	38	28	382	28
Character disorder	106	33	319	37	7	32	53	39	485	36
Other	22	7	110	13	4	18	18	13	154	11
Suicide attempt only	30	9	67	8	1	5	14	10	112	8
Total	323		863		22		137		1,345	

table 5. Individuals who had a diagnosis of psychotic disorder (schizophrenia, affective psychosis, or organic brain syndrome) represented 16 percent (212) of the total group. The diagnoses of neurotic disorders or character disorders made up 64 percent (867) of the total sample. Most of the 11 percent (154) classified as "other" received a diagnosis of adjustment reaction. For the remaining eight percent (112), there was no psychiatric diagnosis other than the recorded suicide attempt. Examination of the relationship of diagnosis to race revealed that for the total group of suicide attempters the diagnosis of psychotic disorder was made more frequently for the white group than for the nonwhite. For the white group, 25 percent (79) of the men and 13 percent (117) of the women were diagnosed as psychotic, while for the nonwhites ten percent (two) of the men and ten percent (14) of the women received a diagnosis of psychotic disorder. The other psychiatric diagnoses given to the nonwhite and white women were similar; however, nonwhite men received proportionately more diagnoses of neurosis or were more often classified as "other" than white men.

Table 6 presents the relationship of psychiatric care received by the suicide attempters to race and sex. Looking at this factor in terms of race, among 30 percent (353) of whites the suicide attempt represented the sole psychiatric contact, while this was so for 52 percent (82) of the nonwhites. And although 62 percent (738) of the white patients received care at some time after their attempt, only 43 percent (69) of the nonwhites received care subsequently. The differences in total psychiatric care were also striking when the white and nonwhite groups were examined by sex. For the men in our sample, 78 percent (252) of the white group, compared with 50 percent (11) of the nonwhites, had received some psychiatric care either before or after the attempt was made; all of the nonwhite men and all but 22 of the white men received care after the attempt. Among women, 67 percent (581) of the whites and 49 percent (66) of the nonwhites had received some psychiatric care either before or after the suicide attempt; for all but eight percent (73) of the whites and six percent (eight) of the nonwhites, care was received after the attempt.

As shown in table 7, three percent (35) of those who attempted suicide from 1964 through 1967 had died by the end of 1968; 51 percent (18) were women. All of the deaths in the nonwhite group were among those aged 25 to 44. In the white group, 52 percent (16) were men and 48 percent (15) were women. Ten of the deaths were attributed to suicide. In fact, suicide was the largest single cause of death in the sample and yielded a crude rate for those who attempted suicide of 595 per 100,000 per year. This is 57 times higher than the rate of 10.4 per 100,000

TABLE 6
Suicide Attempts by Psychiatric Care Received, Race, and Sex

Psychiatric Care Received	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
For suicide attempt only	71	22	282	33	11	50	71	52	435	32
After suicide attempt	104	32	241	28	6	27	35	26	386	29
Before suicide attempt	22	7	73	8	0	0	8	6	103	8
Before and after suicide attempt	126	39	267	31	5	23	23	17	421	31
Total	323		863		22		137		1,345	

TABLE 7
Deaths Among Suicide Attempters Through 1968

Age Group	White		Nonwhite		Total
	Male	Female	Male	Female	
Under 25	1	0	0	0	1
25–44	4	7	1	3	15
45–64	7	5	0	0	12
65 and over	4	3	0	0	7
Total	16	15	1	3	35

per year for suicides in the general population. Of the suicides, three were men and seven were women; eight occurred in persons aged 25 to 44 (two of the men and six of the women). Examination of the suicides by race revealed that no nonwhite deaths were attributed to suicide.

DISCUSSION

Many of the results of our investigation support the findings of previous research. The overall ratio of women to men (3:1), the age distribution, and the marital status of our sample of suicide attempters are all in general agreement with the findings of other studies that have been conducted on this subject (10).

In our sample, we found a suicide attempt rate of 57.30 per 100,000 per year and a ratio of attempted to completed suicides of 5.5:1. If we take into account estimates of the suicide attempts that were treated at other hospitals in Monroe County, we obtain a suicide attempt rate of 74.69 per 100,000 per year and a ratio of attempted to completed suicides of 7.2:1. Even these must be regarded as underestimates, for, as Mintz (5) and others have suggested, many suicide attempts are probably never reported or treated in hospitals.

The overrepresentation of the lower socioeconomic levels in our sample, among both whites and nonwhites, lends support to the finding that the emergency services of general hospitals tend to be used more by the lower classes (11). This overrepresentation suggests: 1) that the suicide attempt rate is higher for people in the lower socioeconomic levels, 2) that they are treated for a wider range of self-destructive behavior than people in other classes, or 3) that people from the upper and middle socioeconomic levels may be treated for suicide attempts in places other than emergency departments of general hospitals, e.g., a private physician's office.

Ninety-two percent of our sample received a psychiatric diagnosis at the time of the suicide attempt; however, relatively few were diagnosed as having a psychotic disorder. For many, the suicide attempt appeared to be only one aspect of more general psychopathology, for some it appeared to have contributed to their receiving psychiatric treatment in the future, and for others it appeared to be the result of a single stressful or disorganized period.

Our study also points out major differences between whites and nonwhites who attempt suicide. Although Hendin (12) has suggested that the rate of completed suicide is higher for younger nonwhites than it is for whites and some suggestions have been made in the literature concerning the higher suicide attempt rates for nonwhites, relatively little has been done in the past to systematically examine racial differences. The data from this investigation suggest that white and nonwhite groups who attempt suicide are two distinct populations that may require different predictive, intervention, and treatment methods. The rate of attempts by nonwhites was 160 per 100,000 per year, compared with 53 per 100,000 per year for whites. The ratio of women to men for nonwhites was 6:1, in contrast to the ratio of 3:1 for whites. The nonwhite group was also younger and more often came from the lower socioeconomic levels. Marital status also separated the whites from the nonwhites. Although the majority of attempts in both groups were made by married or single persons, nearly a third of the nonwhite women were either separated, divorced, or widowed and more than half of the nonwhite men were single. In addition, fewer nonwhites had received psychiatric care either before or after the suicide attempt and nonwhites were less often diagnosed as having a psychotic disorder than whites.

These results could be interpreted as reflecting a lesser degree of psychological disturbance in the nonwhite population, as well as a difference in motives and dynamics between the whites and nonwhites who attempt suicide. However, the data could also be interpreted as reflecting different patterns of care or access to treatment for the nonwhite and the white groups. The lower proportion of nonwhites who received care before and after the attempt could be the result of the availability of fewer facilities to nonwhites or of the reluctance of nonwhites to use existing psychological services or to follow through with referrals. The data could also reflect different diagnostic biases on the part of mental health professionals, or even a "screening-out" process that may selectively exclude nonwhites from treatment. Further research is needed to determine which factors or combinations of factors are involved in these observed differences in diagnosis and patterns of care between the white and nonwhite groups.

There was also a noticeable difference between white and nonwhite groups in the incidence of completed suicide. The high risk for suicide in the suicide attempt group is most impressive among whites. Also of interest is the relatively young age at which the suicides occurred and the relatively short time span between the suicide attempt and the successful suicide. Although nonwhites accounted for 11 percent of the total number of deaths, none was due to suicide, while 32 percent of the white deaths were. This result is somewhat surprising since, for the total county population, nonwhites have a suicide rate of 8.98 per 100,000 per year while the rate for whites is 10.51 per 100,000 per year. Since nonwhites who commit suicide do not as often have a history of attempts, the attempts may not be as predictive of future suicides as they are for whites. For whites, the suicide rate among those

who had previously attempted suicide was much higher than that for whites in the general population. The rates for completed suicide among white suicide attempters were 743 per 100,000 per year for white men and 649 per 100,000 per year for white women, yielding an overall crude rate of 675 per 100,000 per year. This contrasts with an overall rate of 10.51 per 100,000 per year for suicides by the white population of the county as a whole. These findings suggest that among whites the likelihood that a person will commit suicide after an attempt is nearly 64 times as great as for someone in the general population. For nonwhites, however, suicide attempts appear to be negatively related to further self-destructive behavior. These results tend to support the conclusion that the nature of the suicide attempts of whites and nonwhites form two distinct patterns and should not be looked upon or investigated as a common problem with similar motives or prognoses.

This study indicates that people who attempt suicide can be differentiated by race in terms of demographic characteristics, diagnosis, psychiatric history, and the incidence of subsequent successful suicide. It further points out that even though relatively few nonwhites may be treated for suicide attempts compared with whites, the rates of suicide attempts in the nonwhite population are much higher. When treating people for suicide attempts, the physician may note differences between whites and nonwhites in the motivation for the attempt, the treatment techniques that are required, and the degree of risk for further psychiatric difficulty and/or suicide. It is vital that professionals working in the emergency services of general hospitals who deal with people from the lower socioeconomic classes, as well as with proportionately greater numbers of nonwhites than whites, be aware of these differences. In future research on suicide attempts, it would seem imperative to consider race as a separate factor. Not only are there clear differences between the groups but, when the groups are considered together, little information about the nonwhites is uncovered, since there is a relatively large ratio of white to nonwhite suicide attempters in most communities.

REFERENCES

1. Farberow N: Bibliography on Suicide and Suicide Prevention, Public Health Service Publication 1979. Washington, DC, US Government Printing Office, 1969
2. Stengel E: Suicide and Attempted Suicide. Baltimore, Penguin Press, 1969
3. Tuckman J, Youngman N: Identifying suicide risk groups among attempted suicides. Public Health Reports 78:763–766, 1963
4. Bogard H: Follow-up study of suicidal patients seen in emergency room consultation. Am J Psychiatry 126:1017–1020, 1970
5. Mintz R: Prevalence of persons in the city of Los Angeles who have attempted suicide: a pilot study. Bulletin of Suicidology, Fall 1970, pp 9–16
6. Tuckman J, Youngman N, Bleiberg B: Attempted suicide by adults. Public Health Reports 77:605–614, 1962
7. Farberow N, Shneidman E (eds): The Cry for Help. New York, McGraw-Hill, 1961
8. Gardner E, Miles H, Iker H, et al: A cumulative register of psychiatric services in a community. Am J Public Health 53:1269–1277, 1963
9. Babigian H, Odoroff C: The mortality experience of a population with psychiatric illness. Am J Psychiatry 126:470–480, 1969
10. Davis F: The relationship between suicide and attempted suicide: a review of the literature. Psychiatr Q 41:752–765, 1967
11. Jacobs A, Gavett J, Wersinger R: Emergency department utilization in an urban community. JAMA 216:307–312, 1971
12. Hendin H: Black Suicide. New York, Basic Books, 1969

A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients

BY SHELDON H. KARDENER, M.D., MARIELLE FULLER, AND IVAN N. MENSH, PH.D.

An anonymous questionnaire survey of a random sample of 460 physicians revealed that most psychiatrists, obstetrician-gynecologists, surgeons, internists, and general practitioners did not believe in the efficacy of or engage in nonerotic physical contact with their patients. Five to 13 percent of the respondents indicated that they engaged in erotic behavior with patients and five to 7.2 percent engaged in sexual intercourse specifically. The authors point out the need for greater openness and acceptance of discussion about and research in this highly sensitive and vital area.

THE HIPPOCRATIC OATH'S inclusion of an injunction against seducing one's patients clearly delineates this as an age-old concern of physicians. In practicing the art of medicine, doctors have been ethically obliged to judiciously distinguish between transmitting care, comfort, and reassurance in the "laying on of hands" or else transgressing into nontherapeutic or antitherapeutic practices. A combination of factors, including long-standing cultural taboos regarding the discussion of sexual matters, a need to maintain the idealized image of the physician growing out of a priest-practitioner heritage, and rampant ignorance due to a lack of adequate research, have contributed to the maintenance of mythology in all matters sexual. Where there is no fact, fantasy and fallacy flourish.

The historic (1) initial efforts by Ellis, Krafft-Ebing, Freud, Van de Velde, Kinsey, and, currently, Masters and Johnson have attempted to dispel ignorance by providing knowledge that prepares the physician to be of help to his patient. But is the physician, who is subject to the same cultural forces of sexual repression as his patient, prepared to be of help? In order to meet this challenge an increasing number of medical schools in the United States have instituted courses of instruction in the management of sexual disorders (2, 3). With this heightened focus of attention, there logically follows a recrudescence of old concerns regarding the role of the physician himself in relation to his patient.

Reactions to therapists who advocate sexual intimacy as therapeutic (4, 5) have been swift, strenuous, and condemnatory. Others (6–10) have written urging that while such responses may be appropriate, they should be the outgrowth not of blind reaction but rather of serious considerations and open-minded contemplations of the ethical, moral, and therapeutic issues involved, which allow for honest exploration of the question of sexual relations between physician and patient. They point out that guidelines for conduct are blurred and uncertain, as demonstrated by the introduction of each new therapeutic maneuver, i.e., nude marathons, "feeling" therapy, encounter groups, and emergence of a new morality. Further, these authors acknowledge the absence of and need for open discussion, critical appraisal, accumulation of a data base, and honest attempts to develop measures of therapeutic effectiveness.

It is within this spirit of scientific inquisitiveness, which acknowledges both the emotional sensitivity of the subject matter and the absence of existing data, that a pilot study was initiated to determine attitudes and practices of physicians regarding the use of nonerotic and erotic contact with patients.

METHOD

A 32-item, one-page questionnaire was designed that inquired about the respondents' age, years in practice, marital status, and the extent to which they attempted to treat sexual problems in their practice. Six questions followed that asked about their beliefs and practices regarding nonerotic contact with patients. Similarly, seven questions inquired about erotic contact with patients. Respondents were then asked to specify the actual number of patients involved in erotic contact excluding and including sexual intercourse. A final space allowed for other comments. Erotic behavior was specifically defined as that behavior which is primarily intended to arouse or satisfy sexual desire. Most of the questions, except for subjective and demographic ones, were to be answered by circling "0" (never), "1" (rarely—defined as less than five percent of professional experience or opinion), "2" (occasionally—less than 25 percent), "3" (frequently—more than 50 percent), or "4" (always). Two questions required replies specifying the actual number of patients with whom the respondent had had erotic contact.

The authors are with the Department of Psychiatry, School of Medicine, University of California at Los Angeles, Center for the Health Sciences, Los Angeles, Calif. 90024, where Dr. Kardener is Adjunct Associate Professor, Ms. Fuller is Research Associate, and Dr. Mensh is Professor of Medical Psychology.

Computer assistance for this work was obtained from the Health Sciences Computing Facility at UCLA, which is funded by Public Health Service grant RR-3 from the Division of Research Resources, National Institutes of Health.

TABLE 1
Responses to the Question "Do You Attempt to Treat Sexual Problems in Your Medical Practice?" by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
Total	445	11	27	36	26
P	109	3	3	30	64
OBG	78	1	23	49	27
S	68	50	35	9	6
IM	89	3	45	47	5
GP	101	7	34	42	18

A total of 1,000 male physicians were selected by random sampling from the membership list of the local county medical society (N=approximately 10,000). The study sample represented the five specialty groups of psychiatry (P), obstetrics-gynecology (OBG), surgery (S), internal medicine (IM), and general practice (GP), with 200 physicians in each group. The questionnaires identified only the respondents' specialty and were otherwise totally anonymous. Each was mailed with an explanatory cover letter and a stamped, addressed return envelope. The physicians' responses were tallied and the data studied by contingency table analysis (Biomedical Program BMD02S). Chi-square tests were used to determine significant differences between the groups thus analyzed.

RESULTS

General Data

Forty-six percent of the physicians responded (N=460). Four questionnaires were defaced with derogatory or profane comments. There were three letters of complaint that objected to the study and alluded to a (never specified) number of additional physicians who were offended. The questionnaire was sent only to male physicians and did not distinguish between homosexual and heterosexual relationships, since the study concerned itself with attitudes toward eroticism generally. In order to preserve anonymity, the only identifying characteristic known to the investigators was specialty. Therefore this is the only information available regarding nonrespondents.

By specialty, 25 percent of the respondents represented psychiatry (N=114); 23 percent, general practice (N=105); 19 percent, internal medicine (N=89); 18 percent, obstetrics-gynecology (N=83); and 15 percent, surgery (N=69). Chi-square tests indicated a significant difference among the five specialties' response rate ($p<.01$). Forty-two percent of the total respondents were 40 to 49 years old (N=194), and 33 percent were 50 to 59 years of age (N=151). Twenty-six percent reported being in practice for 11 to 15 years (N=117), 31 percent for 16 to 24 years (N=144), and 20 percent for 25 years or more (N=93). Eighty-six percent were married (N=393), three percent (N=14) single, eight percent (N=34) divorced or separated, and three percent (N=14) widowed. (Five respondents did not answer the question about marital status.)

There was a significant difference ($p<.05$) between the number of respondents who reported no prior marriages (81 percent, N=221) and those with one or more prior marriages (19 percent, N=51). The frequency distribution of those with no prior marriages was as follows: surgeons, 96 percent (N=44), obstetrician-gynecologists, 85 percent (N=39), internists, 81 percent (N=46), psychiatrists, 75 percent (N=46), and general practitioners, 74 percent (N=46).

In response to the question "Do you attempt to treat sexual problems in your medical practice?" the five groups responded in significantly different ways ($p<.01$) (table 1). This was due primarily to the differences between psychiatrists and obstetrician-gynecologists as compared to surgeons.

Nonerotic Behavior

Table 2 presents the data obtained in response to two questions regarding nonerotic behavior. Psychiatrists and obstetrician-gynecologists were significantly different in their beliefs, as compared to their internist and general practitioner colleagues ($p<.01$). Practice paralleled beliefs regarding nonerotic behavior with patients, again distinguishing psychiatrists, obstetrician-gynecologists, and surgeons from internists and general practitioners ($p<.05$). The response to questions regarding who initiates such practice indicated that, if it is the doctor, he will most likely be an internist or general practitioner ($p<.01$). Except for the nine percent (N=38) of the physicians who were frequently or always the initiator, all specialties reported that it was most often the patient who

TABLE 2
Responses to Two Questions Regarding Nonerotic Behavior with Patients, by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
"Do you believe nonerotic hugging, kissing, affectionate touching of patients may be beneficial to their treatment?"					
Total	447	32	30	28	10
P	112	30	43	25	3
OBG	81	40	32	16	12
S	65	39	25	26	11
IM	89	27	27	35	11
GP	100	28	22	37	13
"Do you engage in such practices?"					
Total	446	42	33	20	6
P	110	45	41	14	1
OBG	81	48	25	22	5
S	66	49	30	15	6
IM	89	32	34	24	11
GP	100	38	30	25	7

initiated the nonerotic contact, less often was it mutually initiated, and least often by the physician.

In response to the question "Do you believe such behavior would be misunderstood?" significant differences ($p<.05$) existed among the specialties ($N=430$). This was due primarily to the difference between psychiatrists, 69 percent ($N=94$) of whom believed that it would occasionally, frequently, or always be misunderstood, as compared with 40 percent ($N=66$) of the internists. The distribution of responses for the other specialties believing such behavior would occasionally, frequently, or always be misunderstood is as follows: obstetrician-gynecologists, 59 percent ($N=64$), general practitioners, 51 percent ($N=66$), and surgeons, 48 percent ($N=53$).

A subjective-response question asked under what circumstances nonerotic physical contact (holding, hugging, kissing) might be beneficial. Of the physicians responding, 74 percent ($N=184$) recognized the value of such behavior, particularly for providing comfort and in giving tangible support to a patient. The major specialty group explaining the value of this behavior were psychiatrists, 71 percent of whom ($N=53$) in previous responses (table 2) were shown to be least likely to believe in or to engage in nonerotic behavior with their patients.

Erotic Behavior

The data in table 3 indicate responses to several questions regarding erotic behavior with patients.

Erotic behavior other than intercourse tended to consist primarily of kissing; less often of manual or oral stimulation of the patient's genitals; rarely, such stimulation of the physician's genitals; and least of all, mutual genital stimulation.

To the open-ended question "Under what circumstances might erotic behavior be utilized in treatment?" 87 percent ($N=193$) of the respondents reported that it is never of benefit. Their statements included comments on ethical proscriptions, destructiveness to the doctor-patient relationship, dangerous loss of physicians' objectivity, injunctions in the Hippocratic oath, and comments that such behavior was "censurable," "unforgivable," and constituted "professional suicide" or was prima facie evidence of severe psychopathology in the physician. Explanations for the usefulness of erotic practices were offered by 13 percent ($N=28$) of the respondents and included such statements as "improves sexual maladjustments," "helps patients' recognition of their sexual status," "especially in the depressed, middle-aged female who feels undesirable," "for teaching sexual anatomy," "disclosing areas of sexual blocking," "for specific sexual problems [by being a normal partner]," "to demonstrate there is no physical cause for absence of libido," "to relieve frustration in a widow or divorcée who hasn't yet re-engaged in dating," "in mature patients flowing with nonconflicted [love] feelings," and "in healthy patients by mutual consent making the therapy go faster, deeper, and increases dreams."

There was significance ($p<.05$) between these two groups of responses. This was due to the proportionately larger number of surgeons ($N=6$) who favored the use of erotic behavior with patients as contrasted with general practitioners ($N=1$) so stating. In addition, ten psychiatrists, six obstetrician-gynecologists, and five internists gave responses favoring erotic behavior with patients.

TABLE 3

Responses to Three Questions Regarding Erotic Behavior with Patients, by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
"Do you believe erotic contact with a patient may be beneficial?"					
Total	450	80	15	3	1
P	112	80	17	3	0
OBG	81	83	16	1	0
S	66	74	12	11	3
IM	89	85	12	2	0
GP	102	78	17	2	3
"Do you engage in erotic practices?"					
Total	443	95	4	1	0
P	110	95	4	1	0
OBG	79	91	8	1	0
S	65	95	2	2	1
IM	88	95	5	0	0
GP	101	97	1	2	0
"Would this include sexual intercourse with a patient?"					
Total	358	95	4	0	1
P	85	95	5	0	0
OBG	70	94	4	0	1
S	49	94	4	0	2
IM	71	99	0	0	1
GP	83	93	5	1	1

A separate question asked for the actual number of patients involved with the physician in erotic behavior, specifically *excluding* intercourse. Of the responses, 89 percent ($N=277$) reported no such patient contact, while 11 percent ($N=33$) indicated affirmatively by specifying the number of patients so involved. Of those who responded affirmatively, 70 percent ($N=23$) reported that it occurred with fewer than five patients. Similar inquiry was made regarding the actual number of patients involved with the physician in erotic behavior, specifically *including* intercourse. Of these respondents, 89 percent ($N=263$) reported no such contact, while 11 percent ($N=33$) acknowledged such experiences. Of those who reported intercourse with patients, 79 percent ($N=26$) indicated that it involved fewer than five patients.

The four questions "Do you engage in erotic practices?" (table 3), "Would this include intercourse?" (table 3), "How many patients involved, excluding intercourse?" (table 4), and "How many patients including intercourse?" (table 4) served to delineate the incidence of erotic practices. A total of 59 physicians answered one or more of these four questions, while 33 respondents provided information for the last two questions. These data are presented in table 4. The distribution of responses was not statistically significant.

The results of these four questions would indicate that five to 13 percent of the total sample ($N=460$) engaged in

TABLE 4
Comparison of Erotic Behavior by Total Sample and by Specialty

Category	N	Any Kind of Erotic Behavior			Erotic Behavior Excluding Intercourse			Erotic Behavior Including Intercourse		
		Number of Respondents	Percentage of Specialty	Percentage of Total Sample	Number of Respondents	Percentage of Specialty	Percentage of Total Sample	Number of Respondents	Percentage of Specialty	Percentage of Total Sample
Total	460	59	—	12.8	33	—	7.2	33	—	7.2
P	114	12	10	2.6	6	5	1.3	6	5	1.3
OBG	83	15	18	3.3	9	11	2.0	6	7	1.3
S	69	7	10	1.5	5	7	1.1	5	7	1.1
IM	89	11	12	2.4	4	5	0.9	7	8	1.5
GP	105	14	13	3.0	9	9	2.0	9	9	2.0

some kind of erotic behavior with their patients (tables 3 and 4). Similarly, the incidence of erotic behavior, specifically including sexual intercourse, was five to 7.2 percent (tables 3 and 4).

A final space on the questionnaire provided for additional comments; it elicited 124 responses, which were sorted into eight categories. General comments, one of the eight categories, comprised 47 percent (N=58) of these responses and included discussions of the problems that would result from erotic behavior, questions about methodology, and an urging for more teaching in medical schools of sexual matters and for special seminars on this subject for practitioners. Four respondents (three percent) acknowledged that they knew "such things [erotic behavior] go on." Nine (seven percent) stated that sexual behavior should be kept out of the office. Twelve (ten percent) stated that erotic behavior was symptomatic of a doctor's illness. Nine (seven percent) indicated that they did not know if erotic behavior was beneficial or not. Fifteen (12 percent) felt that such behavior destroyed the doctor-patient relationship. Five (four percent) indicated great anger that this study was undertaken, i.e., "proves psychiatrists are nuts," "an insult to even be asked," "you're sick." In contrast, 12 of the respondents' comments (ten percent) were of a congratulatory nature applauding the effort and encouraging continued study.

DISCUSSION

The questionnaire afforded respondents a unique and anonymous opportunity for the expression of participation in unusual practices, and the data are therefore more likely to be representative of such practices. Each specialty represented tended to have its own slightly different orientation regarding engaging in the treatment of sexual problems and beliefs and practices regarding both erotic and nonerotic behavior with patients.

Psychiatrists and obstetrician-gynecologists reported a much higher frequency of the treatment of sexual disorders in their practices and were also more wary of nonerotic physical contact than their colleagues, since they primarily believed that such behavior would be misunderstood. At the same time, it was the psychiatrist who most often explained why such contact might be beneficial in the treatment of a patient. Internists and general practitioners, on the other hand, indicated a belief in and practice of beneficial, nonerotic physical contact with their patients. While surgeons differed sharply from the other respondents in overall response rate and frequency of treating sexual problems, they were, nonetheless, more allied with psychiatrists and obstetrician-gynecologists regarding beliefs and practices of nonerotic physical contact.

The questions regarding actually engaging in any erotic behavior with patients, and in sexual intercourse specifically, indicated a lower incidence (five percent) than did those questions asking for a specific number of patients involved in any erotic behavior (13 percent) and in sexual intercourse specifically (7.2 percent). Possible explanations for this variance include: 1) these questions differed from the others by requiring that a specific number be given and 2) they appeared later in the questionnaire, apart from the patient management considerations per se. Further, physicians participating in this kind of activity with patients do so because they feel they have both a professional and a separate social relationship with these patients. Several respondents specifically gave this explanation on their questionnaires.

It was in the area of belief—not practice—that erotic contact may be beneficial that the surgeons differed from the other respondents (table 3). They constituted 26 percent (N=17) of the total sample of 19 percent (N=88) of physicians who believed that such behavior might be beneficial. Twenty percent of the psychiatrists (N=22) held this view.

It may be worthwhile to compare these responses (19 percent) by physicians with those of medical students, since the latter group represents an earlier phase in the professional career. Wagner (11) reported that 25 percent of the freshmen medical students surveyed felt that sexual intercourse with a patient could be appropriate under the "right circumstances" if the doctor was "genuine" and "authentic." These figures delineate a core of both physicians-in-training and physicians-in-practice, separated by years of age and years of medical practice experience, who are seriously asking, "Why not?" It is a question deserving of an answer and represents an important

challenge to medical teachers engaged in sex education. A greater understanding of the emotional parallel between the doctor-patient and parent-child relationships may provide such an answer. Of particular interest in this regard is Woodbury and Schwartz's study of parent-child incest (12), which indicated an incidence similar to that of the doctor-patient erotic contact reported here.

REFERENCES

1. Brecher EM: The Sex Researchers. Boston, Little, Brown and Co, 1969
2. Romano J: Teaching medical students about population, sexual practices, and family planning. J Med Educ 43:898–906, 1968
3. Stenchever MA: Human Sexual Behavior: A Workbook in Reproductive Biology. Cleveland, Division of Research in Medical Education, School of Medicine, Case Western Reserve University, 1970
4. McCartney JL: Overt transference. Journal of Sex Research 2:227–237, 1966
5. Shepard M: The Love Treatment: Sexual Intimacy Between Patients and Psychotherapists. New York, Peter H Wyden, 1971
6. West LJ: Ethical psychiatry and biosocial humanism. Am J Psychiatry 126:226–230, 1969
7. Braceland FJ: Historical perspectives of the ethical practice of psychiatry. Am J Psychiatry 126:230–237, 1969
8. Branch CHH: Do ethical standards change? Am J Psychiatry 126: 244–245, 1969
9. Van Einde Boas C: Some reflections on sexual relations between physicians and patients. Journal of Sex Research 2:215–218, 1966
10. Dahlberg CC: Sexual contact between patient and therapist. Contemporary Psychoanalysis 6:107–124, Spring 1970
11. Wagner N: Ethical concerns of medical students, presented at the 1972 Western Workshop of the Center for the Study of Sex Education in Medicine, Santa Barbara, Calif
12. Woodbury JM, Schwartz E: The Silent Sin. New York, New American Library, 1971

Answers to Questions of the Month

Page 1070. Question 1:C; Question 2:E.

Psychiatry in Shanghai, China: Observations in 1973

BY DAVID N. RATNAVALE, M.D.

At the invitation of the Chinese Ministry of Health, the author visited China earlier this year. He describes the structure and organization of the Shanghai Psychiatric Institute, a therapeutic community in which the staff and patients work together in a classless social organization, which is part of a medical system that blends the modern and the ancient traditional medical practices. The author presents brief general information on acupuncture and describes its use in psychiatry, but stresses the preeminence of group activities in the therapy of mental illness.

THE CLINICAL MANAGEMENT and care provided to persons suffering from psychiatric illness cannot be described in isolation from the cultural, social, economic, and political milieu from which they spring. Hence, the interpretation of modern trends in a land as ancient and as immense as China is no ordinary task. The problem is further compounded by our scientific requirement of perceiving change through Chinese senses while maintaining an objective investigatory posture.

The people of China, when faced with psychological issues, are reputed to have ready mental access to a vast compendium of "old Chinese sayings." This may simply give them time to ponder before reacting, but it reveals plainly their reverence for the ancient and their readiness to connect the past and the present.

We are now seeing the consequence of Chairman Mao Tse-tung's call during the Great Leap Forward in 1958: "Chinese medicine and pharmacology are a great treasure house. Efforts should be made to explore them and raise them to a higher standard." He has given impetus to the study of ancient Chinese medicine and modern medical science contemporaneously; through the vigorous pursuit of this national policy he has substantially reoriented the entire system of medical practice and teaching in China. Psychiatrists and mental health workers in China tell us that the developments in their psychiatric services parallel the growth observable in all other spheres of human activity and thought since the "liberation" of 1949.

I was invited by the Ministry of Health and the staff of the Shanghai Psychiatric Institute to study current psychiatric practice in China and to share my research experience in Sri Lanka (formerly Ceylon), where I had investigated the difficulties inherent in any attempt to blend the ancient indigenous (ayurvedic) medical system with Western medicine. This paper presents a description of a hospital in Shanghai, one of the world's largest cities, in the Kiangsu Province of the People's Republic of China. I shall attempt to identify modern trends in psychiatry and the therapeutic modalities in use. Special attention will be paid to acupuncture in psychiatry and therapeutic group processes.

At the time this paper was written, Dr. Ratnavale was a senior psychotherapist at Chestnut Lodge, Rockville, Md. He is now Associate Professor of Psychiatry, Eastern Virginia Medical School, 721 Fairfax Ave., Norfolk, Va. 23507.

SHANGHAI PSYCHIATRIC INSTITUTE

The Shanghai Psychiatric Institute, constructed in 1958, is a large complex of modern concrete buildings situated in a surburban section of Shanghai. The 1,000-bed hospital and the specialized departments that serve it cover half the total area of the premises (40,000 square meters), which itself is enclosed by a cinnamon-colored wall three meters high. Directly across the road—Chin Chi Road—lies the impressive Lon Hwa General and Teaching Hospital.

As one enters the imposing gates of the Shanghai Psychiatric Institute, one's gaze is met by a tall rectangular slab of cement bearing a quotation of Chairman Mao Tse-tung about freedom. The buildings of the institute surround a spacious garden-like courtyard where patients are seen at play; it is tastefully landscaped with flowering and evergreen trees.

The hospital is divided into 13 airy and plainly furnished units with rooms that sleep eight to 16 patients. The patients have the responsibility for maintaining their quarters but are assisted in this function by the nurses and health workers. There are a few single rooms but these are rarely used, since the isolation of patients is strongly discouraged. On one wall of every unit is painted an appropriate quotation from Chairman Mao, e.g., "Help one another; care for one other; love one another."

The Psychiatric Institute is served by a staff of 556 persons. Fifteen administrators, four of whom are psychiatrists, under the chairman of the revolutionary committee of the hospital, are responsible for managing the institution. Dr. Yen Ho-Chun, a psychiatrist, is the medical director. His assistant, Dr. Shu Sun-Ha, is also the vice-chairman and has just completed two years of specialized instruction at a famous center for Chinese traditional medicine. Of the 61 psychiatrists, 11 are women. All have received training in both modern Western medicine and traditional Chinese medicine.

At any given time as many as a third of the staff psychiatrists are away in rural areas serving with other specialists on mobile medical teams for as long as six to 12 months. There they are engaged in treating patients, instructing commune and barefoot doctors (*chú chiao*—"a peasant who has had basic medical training and gives treatment without leaving productive work" [1]), and disseminating information on mental health. Their rural encounter is also considered to be a learning experience.

A distinctive feature of the working staff of the hospital, which includes 218 nurses, is the absence of any insignia of rank. Indeed, my overall impression was that staff members were under less stress than their fellows in other lands and I was struck by the ease of conversation among professional, paraprofessional, and patient.

The Shanghai Psychiatric Institute and similar institutions provide treatment facilities for the whole society; it is asserted that, in the preliberation period when adequate health care was available only to the privileged classes, "hospitals did not satisfy the needs of the people." The patients are now receiving the benefits of both the traditional Chinese and the modern Western medical systems and treatment is provided for all types of mental illness. The outpatient clinic is reported to receive as many as 400 patients a day, the majority suffering from neurotic and psychosomatic conditions. A small percentage of patients with epilepsy are also seen for checkups or renewal of medication. On the average, hospitalization lasts for ten to 12 weeks and families generally visit patients twice a week. There is no charge for therapy, but a small payment is sometimes levied for food.

There is no separate staff category that corresponds to our social workers. The functions of social work are absorbed by the working staff, who maintain steady contact with families and with members of the patients' working units. Every patient is certain that his job will be waiting for him when he returns to work.

The inpatients range in age from 20 to 35. The incidence of psychiatric disorders below the age of 15 is said to be very low. Indeed, the absence of aged, regressed, or agitated patients is also striking. Over half the patient population suffers illness of psychotic proportions, chiefly schizophrenic syndromes. The psychiatrists are unanimous in their claim that the incidence of depressive syndromes (*yu yiu-tsen*), postpartum psychosis, and suicide is significantly low. They also note the rarity of senile psychoses—an observation recorded by Tsung-Yi Lin in another Chinese community (2).

They also asserted that chronic alcoholism, opiate addiction, and drug abuse in general had been eliminated, and I concur with the group of American physicians who visited China in 1971 that "not a single instance of drunkenness was observed day or night in our travels in the cities and countryside" (3). Our Chinese colleagues attribute their success partly to widespread educational campaigns and partly to the efficient halting of illicit production. Lowinger (4) considered "the changed ideology of the young people . . . the changes in outlook, which included a redefinition of the nation and its youth, of their worth and role" to be a major force. Indeed, the eradication of the poppy fields in a land that is 80 percent "countryside" and the recultivation of these fields with food crops indicates the size of the task and the efficiency of the programs.

The newer developments within the Shanghai Psychiatric Institute are identified with parallel changes in the nation as a whole; they indicate that a shift in the attitude toward mental patients and their care followed in the wake of the "great proletarian revolution" under Chairman Mao's leadership. He is quoted frequently as a source of guidance and inspiration and his sayings are conspicuously displayed in all public places. He is seen as a true advocate of the classless society, in which all hospital workers and all patients belong to one socioeconomic category, and all remember his exhortation to approach patients "with wholeheartedness," "paying attention to environment and past beliefs." He sponsored the revival of ancient and traditional medicine (including acupuncture) and the establishment of equal status for modern Western-oriented physicians (*si-i*), barefoot doctors (*chú-chiao*), and traditional healers (*zjung-i*).

The physicians and health workers at the Psychiatric Institute emphasized the point that, in line with the concept of a people's republic, the hospital is perceived as a people's hospital, and they were generally inclined to view each ward or hospital unit as a family.

TREATMENT: METHODS AND PHILOSOPHY

The preeminent therapeutic emphasis appears to be related to the reestablishment of a "sense of group" or "sense of belonging." The group therapeutic activities include ideological education, play, singing, reading, and "heart-to-heart talks." One can add "group acupuncture" to this list since acupuncture is now administered to more than one patient simultaneously. Chemotherapy, herbal medicine, and acupuncture comprise the nonpsychological approaches. Electroconvulsive therapy and insulin shock treatment have been discontinued.

Chemotherapy

The standard Western psychopharmacological products (e.g., tricyclic antidepressants and phenothiazines) are used, along with herbal preparations. In general, the dosages are smaller than those prescribed in the West; 250 mg. of chlorpromazine per day is considered to be a high dose. It is suggested that the concurrent administration of herbal medicines reduces the need for higher dosages. The Psychiatric Institute maintains a large herb pharmacy that dispenses pills and decoctions manufactured from medicinal roots, bark, and leaves.

Acupuncture

Acupuncture appeared in Central Asia as early as the Neolithic period and its application has been passed down to us through a few records. An extensive exposition is found in the *Huang-ti Nei Ching Su Wen* [*The*

Yellow Emperor's Classic of Internal Medicine] (5), whose composition is placed by some authorities at 2697 B.C. and by others at the third to fifth century B.C. (6). A textbook, it takes the form of a dialogue or "familiar conversations" between Huang-ti the Emperor and his minister-physician Ch'i Po. Students of Chinese medicine look to the *Nei Ching* not only to read medical history, but also to understand its development and current usage.

Acupuncture consists of the insertion of needles into particular points on the body that lie along 12 channels or *ching* (*ching lo* theory). These *ching* are said to be deeply set and not in direct communication with the blood vessels but to emerge to the surface at 365 or more places, presenting the points for needling. The anatomical locations of these *ching* have yet to be defined. Acupuncture, which is widely practiced in China, involves an understanding of the principles of *yin* and *yang*, maintaining a balance between *ch'i* (air) and *shiueh* (blood), and "needling," which establishes equilibrium by removing stagnation and neutralizing excesses.

The use of acupuncture in psychiatry and anesthesia is of relatively recent origin. Though its use in psychiatry has not been adequately reported in the literature, despite its regular use in Chinese mental hospitals, acupuncture anesthesia has won considerable publicity and is extensively employed in China (by conservative estimate it has been used in more than 400,000 operations since 1968) with a 90 percent reported success rate.

The Melzack-Wall hypothesis (7) offered some hope of a neurophysiological explanation for acupuncture anesthesia, but the answer remains unsettled. This hypothesis holds that perception of pain involves a "gate control" system, primarily located in the substantia gelatinosa of the spinal cord, and that effective closure of this "gate" blocks pain from reaching the higher centers. Man and Chen (8) postulated that there is a second gate in the thalamus, while others have summarily dismissed the phenomenon as something that makes "no sense anatomically" or that it is due simply to the effect of distraction and hysteria. Even serious students have been vocal about the "power of suggestion," but they are hard pressed to explain what they mean. Cooperative exploration by psychologists, psychiatrists, and neurophysiologists is surely called for. Huard and Wong (6), reporting on acupuncture in psychiatry, noted that "in psychiatry the effect of acupuncture is nonexistent, and hysterical and coxalgic patients have been seen to resist the needles but not the electric shock" (p. 215). Sidel (9) has reported the use of acupuncture in treating schizophrenia, excitement, catatonia, and depression.

I observed the administration of acupuncture to patients individually and in groups at the Shanghai Psychiatric Institute, where acupuncture has been in use since 1966 and is now standard treatment. Psychotic and neurotic patients are given acupuncture along with other types of treatment. It is considered particularly helpful in treating syndromes characterized by excitement, anxiety, apathy, catatonic stupor, and depression. Points on the limbs and trunk have been identified for needling in psychiatric conditions; they lie along the standard *ching*, but why these points have been selected over others has still to be explained. Future research must satisfy this question and also establish the specific value of this form of treatment.

Eleven points reported to be specific for psychiatric illness are: *ho ku*, a *yang ching* on the extensor aspect of the hand in the muscle belly of the first dorsal interosseous muscle; *nei kuan*, a point on the flexor aspect of the forearm one inch from the wrist crease; *lau kong*, in the center of the palm; *shiao shang*, a *ying ching* on the outer aspect of the nail bed of the thumb; *tsu san li*, a point one inch below and behind the head of the fibula; *tai shung*, on a line between the first and second toe, two fingerbreadths above the web; *yung chuwan*, on the sole of the foot at the junction of the anterior and middle third; *yi fong*, on the posterior aspect of the ear lobe; *tin kong*, immediately anterior to the tragus of the ear; *bei wei*, on the center of the scalp; and *tai yang*, at the temple.

During acupuncture the patient usually complains of a mild local "soreness," "distension," or "tightness." Manual twirling of the needle is still practiced but more commonly a current of four to six volts is passed to the implanted needle via a portable regulator box no bigger than a small transistor radio. The box, with several terminals, allows for treating more than one patient (as many as six) at a time and requires only one therapist. Each treatment lasts 20 to 30 minutes and is administered twice daily, daily, or three times a week. A positive response (essentially the reduction of symptoms) is usually noticed after two weeks of treatment, but the course generally lasts from five to six weeks. If no improvement is noted in three weeks the method is discontinued.

The doctors at the Shanghai Psychiatric Institute implied that acupuncture has replaced ECT in their hospitals but they do not, at this stage, venture any definite explanation of its action. They list its advantages over ECT and note primarily its safety, simplicity, and availability and the absence of such side effects as memory impairment. It must be emphasized that doctors and scientists in China make no pretense of fully understanding the action and effect of acupuncture and that active research is going on in this area.

Therapeutic Group Processes

Group play at the Shanghai Psychiatric Institute chiefly involves uncomplicated noncompetitive games. Groups of patients are seen lobbing a basketball to one another in a game that resembles "catch." Another game consists of tossing a rubber ball or shuttlecock to a partner with a wooden paddle. In table tennis, however, a little of the competitive spirit is evidenced.

In group singing patients and nurses stand around a pianist and violin player and sing animated folk songs or songs of victory that have a somewhat martial flavor and that deal with liberation and freedom.

In group reading patients or health workers take turns reading simple literary works, news reports, or children's books.

"Heart-to-heart talks" amount to informal chats in small groups or individually with a psychiatrist or nurse.

Ideological Education

By far the most emphasized therapeutic group activity is ideological education. It is given to all patients at some period of their hospital life. A newly admitted acutely disturbed or confused patient does not participate in this mental exercise until the ward psychiatrist, nurse-instructor, and patient group acknowledge his ability to become involved.

This method is aimed at "mobilizing the patient's initiative" through discussions, questions, and the examination of such famous works as the teachings of Chairman Mao. The subject matter is concerned with objectivity, freedom, openness, equality, and caring for one another and represents the basic material for ideological education. Learning and discussing the teachings of Chairman Mao, it should be noted, is a popular and serious activity in all spheres of life in China; reading, studying, and debating his works is considered to be a highly salutary pursuit. It is understandable that this would be a part of hospital life.

In these sessions, asking questions and repeating them until they are satisfactorily clarified is greatly encouraged. There are thus no "stupid questions," only comrades who cannot adequately explain their answers. For example, a group may be engaged in the study of Mao Tse-tung's writing on "Where do correct ideas come from?" or "Can bad things be turned into good things?" This would be the basic material for exploring the ideas and feelings of the patients. In one such discussion, the nurse-instructor (the group leader) expressed the view that, in interacting with patients, a group leader "must not be critical, but instead willing to explore the conflict that led to the patient's puzzlement or false ideas; that an atmosphere of trust must be created and engendered; that investigations and explorations should be wholehearted and intensive."

Case Report

The following report was related to me by a psychiatrist at the Shanghai Psychiatric Institute[1]:

A woman nearing the age of 50 (the usual retirement age) was informed by her working unit that she was going to be retired. She had a "false thought" that she was being expelled and wondered whether she was to be dismissed because her ability and performance were poorer than those of the other workers. She got the idea that if she worked hard she might be offered the opportunity of working two shifts instead of one. She was, of course, actually ill. In addition, she had insomnia and loss of appetite. At the institute her treatment consisted of chemotherapy, acupuncture, and group activities.

In her group, she was urged to compare the past and the present, the time before liberation and the present time. She was reminded that in the past the old workers, the aged workers, were "kicked out by the capitalists" and that it was very difficult for them to obtain any pension or other support. Her "actual" current situation and the new labor regulations that provide certain guarantees were explained to her. She was helped to recognize that there was glory in the work she had already done and that she could retire with the feeling that her career was one that brought glory to herself and to her country. She was helped to see that her thoughts were distorted and therefore wrong. She enjoyed and benefited greatly from her group experience.

Follow-up of her case was carried out at the outpatient clinic; weeks after her discharge the unit wrote to her and she replied with news of her improved state. In cases of this kind, the "visiting team" would go to the patient's home or working place to check on her progress and to help "consolidate the efficiency" of her improved state. Her treatment was therefore a combination of chemotherapy, acupuncture, and group therapy. Follow-up aided in consolidating her gains and facilitating the development of a new relationship between her and her fellow workers.

We are frequently disappointed when our theoretical conceptualizations fail to explain the action or results of techniques unfamiliar to us. The language is the same but the dialects are different, a situation that creates no less misunderstanding than has existed between so-called organicists and those considered psychodynamically oriented.

How are we to understand the clinical example cited or the statement that "ideological education is offered in a way that helps to integrate and reorganize a patient's thinking"? Is it enough to accept therapeutic efficacy simply in terms of realigning illogical thought through a dialectic process (defined as the art or practice of examining opinions or ideas logically, often by a method of question and answer so as to determine their validity), or can we safely assume that other psychological events are taking place concurrently?

We are faced with the task of translating traditional Western concepts concerned with such things as the mother-child relationship, ego development, psychosexual phases, psychic trauma, and transference to the state of affairs that prevails in China and of opening our minds to new ideas. In such a pursuit it would be wise to guard against too hasty a presumption that our Chinese colleagues organize these concepts along similar lines but within a framework that we do not as yet understand. They are willing to share their clinical experience and for this privilege we are obliged to study *with them* the intricacies of the methods they employ. We are called upon to face simple questions related to causation and curability. In a field that has no universal criteria for cure, we must at least be content to accept as a primary consideration a patient's capacity to return to his work and his home life.

If we begin to scrutinize one of the primary psychological therapies practiced at the Shanghai Psychiatric Institute, with an inclination to view it as a form of group therapy, it would be perfectly valid to ask why it receives their main emphasis, what makes it an effective modality, and how it works.

In the West, and especially in the United States, group therapy as a psychotherapeutic method has almost lost the stamp of science. Its exponents vary from psycho-

[1] When I asked whether this patient's case would fit in the category of depressive illness, I was informed that she had received a diagnosis of "involutional melancholia."

analysts to nudists, and it has come to mean (in the public eye) any type of group activity that ameliorates psychic tensions and that facilitates improved interpersonal relationships. Regrettably, there is little consensus regarding the indications for group therapy, although there is general agreement that people who are deprived of adequate group experiences or who are unduly uncomfortable in groups can benefit from such treatment. We also know that cultural and social factors—one's concept of family life, of independence and autonomy, of intrafamily loves and jealousies—all influence attitudes toward one's self and one's fellows.

Reduced to its simplest meaning, group therapy aims at the evolution of a sense of group or the redevelopment of that sense, once known but abandoned. Within this simple context, it might be profitable to consider the meanings of "group sense" to a person in Chinese society today and its value and significance in group treatments in Chinese mental institutions.

The attitude of Westerners toward China has fluctuated considerably during recent centuries and has significantly influenced Western perceptions of the Chinese character. Anthropologists and social scientists speak of the Chinese need to "save face" and their "inscrutability." Western LaBarre (10), writing in 1946, noted that "the Chinese are not militaristic . . . not imperialistic . . . non-mercantile . . . and not essentially an urban people." Weakland (11), in "Orality in Chinese Conceptions of Male Genital Sexuality," discussed their "oral thinking." Hsein Rin (12) noted the marked emphasis on orality in the Chinese, giving as evidence "the frequent and prolonged breast feeding of babies and the prominent and almost exclusive role of mothers in bringing up children." Tsung-Yi Lin (2) observed that "the threshold of Chinese families in regard to abnormal behavior is rather high." Muensterberger (13), in a study of the character of the southern Chinese, wrote that "those who know report that, although the Chinese woman suffers under many restrictions, she plays a more influential role within her family than does the man."

In general, students of Sinitic studies agree that, however alien the surroundings, the fundamental and centrally organizing factor in Chinese social life is the family. That this appears to be true of modern China is hard to dispute, and a discussion of the persistence of this characteristic in the face of radical alterations in role functions and expectations in the present-day Chinese family group is a worthwhile project.

ASPECTS OF GROUP CONSCIOUSNESS

The meaning of the group may well be somehow different in China, but there is evidence to suggest that the group has a highly therapeutic meaning. Interpreting national policy and its influence upon Chinese society is beyond the scope of this paper, but reference must be made to current developments within the nation that appear to significantly enhance group consciousness throughout life. At least four intimately related areas deserve our close attention: 1) the reverence toward children in modern China, 2) the liberation of women, 3) a heightened awareness of the oppressed minorities, and 4) the popularity of "speaking bitterness." Inherent in these phenomena is a recollection of how things used to be and an affirmation of the positive changes that have been made.

Reverence for Children

Despite historical references to poverty-stricken eras when parents were driven to extremes, the Chinese love of children is taken for granted. This basic attitude is being augmented by present-day leadership. Mao Tse-tung has said: "The world is yours, as well as ours, but in the last analysis it is yours. You young people, full of vigor and vitality, are in the bloom of your life, like the sun at eight or nine in the morning. Our hope is placed on you. The world belongs to you. China's future belongs to you."

From very early in an infant's life, as early as 56 days old, he might be placed, like 90 percent of his peers, in the nursing room of the factory where his mother works. She will come to feed him at least twice each day, but during the rest of the working day he is in the care of several "aunties." These aunties, or auxiliary mothers, are selected from among the workers and chosen for their patience, warmth, and heightened sense of responsibility. Thus, quite early a mother begins to rely on other people to assist her in rearing her babies, and the child comes to recognize that he is a member of a group. Indeed, the children feed together, play together, and after breakfast sit on individual potties and have their bowel movements together.

News about new schools and about developments in education is widely disseminated. Under the title "More Nurseries and Kindergartens in Tienstin," the *Chinese Medical Journal* (14) reported: "In addition to singing and dancing lessons, the children learn to tend vegetable gardens and raise chickens and rabbits in order to inculcate in them the love of labor," and under the title "Better Health for Tibetans": "Nurseries and kindergartens are staffed, in the main, by young women who have received special training in child psychology, health protection, and nutrition. Research work is being conducted to improve the care and education of pre-school age children. Meetings of child care workers, for exchanging experiences, are held regularly."

Women's Liberation

It is generally believed that, until recently, women held an inferior position in China and were the voiceless, faceless, footbound servants of their masters, gaining a modicum of status only upon becoming mothers-in-law. New marriage laws, social changes, and raised expectations have altered their traditional postures so that now they kowtow to no one, enjoy equal rights, and receive equal pay for equal work. R. Sidel's observations (15) lend credence to these changes, noting also that basic attitudes toward motherhood remain stable.

Oppressed Groups of Past Days

It is well known that in bygone times peasants and minority nationalities, especially in remote regions, were at the mercy of warlords who plundered their produce and held them in fear and submission. These groups are now enjoying the limelight in a conscious, deliberate manner. The theater, opera, and radio consistently depict their earlier predicament and compare the past with the present. It would appear that the term "minority" is frequently equated with "underprivileged," in a way that expresses the earlier status of the peasant classes (who, though numerically in the majority, were the minority in a social and economic sense).

Speaking Bitterness

"Speaking bitterness" refers to a phenomenon that became very popular and was greatly encouraged after the liberation. Through "speak bitterness" meetings, an acceptable forum was created for people to describe their past hardships in a dramatically cathartic fashion. It served to purge one's impacted resentments and, through identificatory processes, the bitter feelings of their hearers as well. It served also to identify the present politicosocial system as one that rescues and nurtures, but apparently it did not stop there. Rather than foster a helpless dependency, the will of the individual and the group was bolstered into recognizing that only through their group consciousness, vigilance, and hard work could the present gains be protected and sustained.

Only four areas have been portrayed; presumably there are more. They have the quality of novelty and whet one's curiosity. Yet, they sound like old ideas or just ordinary sentiments. They seem to remind us that children have always been cherished—and needed it; that women invariably exerted profound psychological strengths—and needed to; that the oppressed and small at all times found an advocate; and, last but not least, that people have always complained.

I recognize the difficulties inherent in the interpretation of unfamiliar methods and ideas. I would caution against hasty generalizations and urge a deeper study of the topics discussed in this paper.

ACKNOWLEDGMENTS

I wish to thank my Chinese hosts, my colleagues at the Shanghai Psychiatric Clinic, and their patients for their trust and generosity. Without their help and the unhurried assistance of Dr. Yu Lu-yi and both Mr. Chiang and Mrs. Wu Sheu Cheng of Shanghai's Municipal Bureau of Public Health this work would not have been possible.

REFERENCES

1. Everybody works for good health. China Reconstructs 10(11):20–22, 1971
2. Lin T-Y: A study of the incidence of mental disorder in Chinese and other cultures. Psychiatry 16:313–336, 1953
3. Notes on drugs and therapeutics in the People's Republic of China. Med Lett Drugs Ther, Sept 1, 1972, pp 65–68
4. Lowinger P: How the Chinese solved their drug problem. Medical Opinion 2(3):81–92, 1973
5. Huang-ti Nei Ching Su Wen [The Yellow Emperor's Classic of Internal Medicine]. Translated by Veith I. Berkeley, University of California Press, 1966
6. Huard P, Wong M: Chinese Medicine. New York, World University Library, 1968
7. Melzack R, Wall PD: Pain mechanisms: a new theory. Science 150:971–979, 1965
8. Man PL, Chen CH: Acupuncture "anesthesia": a new theory and clinical study. Curr Ther Res 14:390–394, 1972
9. Sidel R: Medicine and Public Health in the People's Republic of China. Washington, DC, US Government Printing Office, 1972, p 295
10. LaBarre W: Some observations on character structure in the Orient, part 2. Psychiatry 9:375–395, 1946
11. Weakland JH: Orality in Chinese conceptions of male genital sexuality. Psychiatry 19:237–247, 1956
12. Rin H: A study of the aetiology of koro in respect to the Chinese concept of illness. Int J Soc Psychiatry 11:7–13, 1965
13. Muensterberger W: Orality and dependence: characteristics of Southern Chinese. Psychoanalysis and the Social Sciences 3:37–69, 1951
14. Notes. Chinese Medical Journal 82:64, 1963
15. Sidel R: Women and Child Care in the People's Republic of China. New York, Hill and Wang, 1972

Evolving Behavior in the Clinical and Experimental Amphetamine (Model) Psychosis

BY EVERETT H. ELLINWOOD, JR., M.D., ABRAHAM SUDILOVSKY, M.D., AND LINDA M. NELSON

A parallel is drawn between several behavioral constellations observed in the evolution of the human amphetamine psychosis and the motor-postural-attitudinal manifestations induced in animals by chronic amphetamine intoxication. On the basis of the results reported, a triple-layered model of psychosis is suggested and the roles played by participating neurotransmitters and mechanisms are further elaborated.

IN A CLINICAL SETTING, the amphetamine psychosis develops over a period of time as the user gradually increases his intake of amphetamine to amounts ranging from 150 to 2000 mg. per day. Although the paranoid psychotic state evolves gradually as a result of this chronic abuse, the patient is seldom seen by a physician until the process is far advanced. By this time he presents a fairly distinct syndrome, with delusions of persecution, ideas of reference, visual and auditory hallucinations, changes in body image, hyperactivity, agitation, and panic.

In previous studies we have asked whether there are behaviors that precede the last stage and may, in fact, be related to the development of the paranoid schizophrenic-like picture. More specifically, we have been interested in the anlagen of the behaviors that evolve over time since several of the antecedent behaviors we have observed in human chronic amphetamine abusers present fairly distinct constellations or clusters (1, 2).

One of these constellations involves an intense feeling of curiosity, often manifested by repetitious, stereotyped examining, searching, and sorting behaviors. This repetitious activity has been variously called "punding" (3), "hung-up activity" (4), "obsessive-compulsive tendencies" (1, 5), and "knick-knacking" (by inhabitants of the Haight-Ashbury scene). Its characteristic feature is engagement in tasks that primarily involve small bits or minutiae and a marked enhancement of perceptual acuity directed toward these minute objects. At times there are perceptuo-motor compulsions, manifested as repetitious stringing of beads or as acts of arranging, sorting, and lining up pebbles, rocks, or other small objects (2). Most of the so-called "speed art" is replete with complicated syntheses of a multitude of minute details, often depicting universal themes or mandalas. Speed users are frequently observed taking apart such objects as television sets, watches, radios, and phonographs. Subsequently, the parts may be analyzed, arranged, sorted, filed, and cataloged and, rarely, put back together (2). Many patients report a sense of satisfaction associated with this compulsive-like conduct.

Perhaps the best-known example of searching and examining behavior is that of Sherlock Holmes, whose cocaine habit was described by Dr. Watson:

> Finally he thrust the sharp point home, pressed down the tiny piston, and sank back into the velvet-lined arm-chair with a long sigh of satisfaction. Three times a day for many months I had witnessed this performance. . . .
>
> "It is cocaine," he [Holmes] said, "a seven-per-cent solution. . . . I suppose that its influence is physically a bad one. I find it, however, so transcendently stimulating and clarifying to the mind that its secondary action is a matter of small moment. . . .
>
> "My mind," he said, "rebels at stagnation. Give me problems, give me work, give me the most abstruse cryptogram, or the most intricate analysis, and I am in my own proper atmosphere. I can dispense then with artificial stimulants. But I abhor the dull routine of existence. I crave for mental exaltation. That is why I have chosen my own particular profession, or rather created it, for I am the only one in the world. . . .
>
> "To the trained eye there is as much difference between the black ash of a Trichinopoly and the white fluff of a bird's-eye as there is between a cabbage and a potato."
>
> "You have an extraordinary genius for minutiae," I [Watson] remarked (6, pp. 610–612).

Holmes's description of his "grooving on" puzzles and cryptograms and his penchant for magnificent synthesis of details to solve a given case are quite analogous to the amphetamine addict's intense curiosity and preoccupation with minutiae. Even at a low point in the drug-use cycle, these persons will seek out stimulating mechanical or intellectual puzzles. This compulsion for analysis is widely recognized in the "speed scene."

Amphetamine addicts frequently state that the early scanning, prying, probing behaviors subsequently evolve into a pleasurable sense of "suspiciousness" in the origi-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the Behavioral Neuropharmacology Section, Department of Psychiatry, Duke University Medical Center, Durham, N.C. 27710, where Dr. Ellinwood is Director and Professor of Psychiatry, Dr. Sudilovsky is Research Associate, and Ms. Nelson is Senior Research Technician.

This work was supported by Public Health Service grants MH-07073 and MH-18904 from the National Institute of Mental Health and by funds from the Veterans Administration.

nal meaning of the word—that is, looking beneath the surface for the truth or meaning (literally, "to look from below"). They describe looking for meaningful details or relationships between details.

Another progressive symptom noted by these patients is increased thinking about "meanings and essences." Insights are frequently received as significant major revelations, or "eureka experiences." For example, one patient stated, "I put things together from the past and present. Now I think I know what is going to happen to this world." These sudden emotional insights and the compulsion to analyze a variety of details to find meaning and explanation were common to both philosophical and delusional concerns (2).

Later in the course of amphetamine addiction, the direction of the inquisitive behavior is reversed and the addict feels that other people are probing—watching and spying on him. At this time the previously pleasant suspiciousness takes a more paranoid form, leading eventually to fear or even agitation, hyperreactivity, and panic. The addict may then begin to misinterpret stimuli and often to have illusions and hallucinations. Thus it might be said that the initial periods of pleasurable curiosity and suspiciousness set the stage for the eventual paranoid reaction.

EXPERIMENTAL STUDIES IN ANIMALS

In the experimental laboratory, chronically intoxicated animals manifest evolving clusters of behavior comparable to those just described in amphetamine addicts (7). In our experiments we have used the operational approach that the laboratory observations have heuristic value in elucidating the nature of the amphetamine psychotic state itself; we are summarizing in this paper the animal behaviors that are analogous to those seen in human amphetamine abusers. The details of these experiments, performed on rats, cats, and rhesus monkeys, have been reported elsewhere (7–11).

Stereotypies

Stereotyped movements are the hallmark of both acute and chronic amphetamine intoxication. They may consist of a single activity performed continuously or a sequence of a few activities that dominate behavior (8, 12, 13). Usually these stereotypies appear nondistractible and "driven" (performed in a rapid, repetitious manner). They most often evolve from motor components of investigative behavior. In both our acute and chronic intoxication studies across species, the one common denominator of amphetamine-induced stereotyped movements was that they were composed of patterns of searching and examining (10). The motor components, at least, of these patterns are present in the stereotypies of all species studied.

In macrosmatic animals, such as the rat, the primary stereotyped mode is that of sniffing, although biting and licking are also noted. As one moves up the phylogenetic scale to cats, the sniffing movements remain, but head movements associated with looking are also prominent. In primates a new dimension, eye-hand examination patterns, is added. These hand movements are quite specific and consist primarily of forefinger probing, pincer-like grasping, picking, palm-clasping, and hand-examining. The underlying postural-motor components are similar in all of these motor activities. An individual motor component of the searching-examining patterns can be integrated into several stereotypies and may be directed either toward external objects or toward the animal's own body (as in patterns of grooming).

Over time, the stereotyped patterns become more repetitious and more constricted. Figure 1 illustrates the gradual constriction of a cat's head and neck movements that orient the head for visual regard. Over a period of two weeks, the orienting background movements often tend to drop out, leaving a small, pecking-like movement of the head in an extremely constricted pattern, as if the cat were sniffing at a small crumb or tiny morsel of food.

Attitudes and Postures

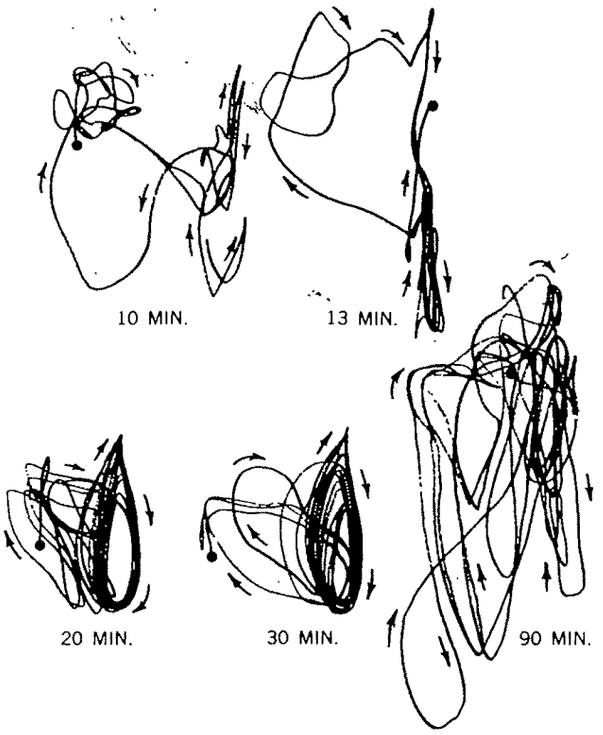
One of the most characteristic series of changes observed in cats during the period of chronic intoxication occurred in the animal's attitude.[1] The most frequent characteristic of early amphetamine intoxication was an abnormal investigative attitude—operationally defined as actively reaching out to or approaching restricted elements of the environment, with an excessively compulsive appearance. The evolution of the stereotyped motor behavior was intimately related to the abnormal investigative attitude (figure 2) and at times this attitude would persist in a given animal even after the motor stereotypy had ceased.

Another distinctive attitude, which appeared primarily in the later days of the intoxication cycle, was the reactive attitude—characterized by sudden, disproportionate startle reactions with a jumpy, agitated quality. This abnormal reactiveness was heralded by an increase in the speed and suddenness of movements and was later accompanied by a general increase in activity and agitation. At times the animals' movements were suggestive of akathisia and dyskinesia. In the end stages of the chronic intoxication cycle, even though the animal might be in a frozen posture, sudden orienting movements toward a real or "hallucinated" stimulus were often observed. Many animals appeared to be increasingly aware of minor stimuli in their environment and acutely apprehensive about it.

This intense hypersensitivity to the environment was a dramatic reversal of the complete disregard for transient environmental stimuli that characterized the abnormal investigative attitude. Although in the end stage much of the reactiveness appeared to be oriented toward "internal" cues, there was no question that minor external stimuli often overwhelmingly impinged on the animal in a way that triggered a fearful, overreactive orienting response. A slight, remote sound in the laboratory, for ex-

[1] In our studies "attitude" is operationally defined as body posture and activity in relation to the environment. This includes the animal's regard and reaction not only to his surroundings but also to his own body.

FIGURE 1
*Progress of the Tip of a Cat's Nose, Traced from a Slow-Motion Videotape**



*Each tracing represents 30 seconds of activity at the indicated time after the injection of amphetamine on day 1.

ample, might cause a violent turning of the head or jumping by a cat that ignored gross movements within its immediate field of vision. Or a glimpse of its own image on the shiny wall of the cage would cause a cat to jump back in apparent panic. Not infrequently a cat would jump back and turn vigorously to one side in response to a nonexistent (apparently hallucinatory) stimulus.

In the early days of intoxication, the persistent restrictiveness and directedness of the animals' behavior were reflected in their "postural-attitudinal" set as well as in their stereotyped movements. As intoxication progressed, however, there was increasing dissociation between the animals' underlying postural base and the superimposed movements and attitude. Toward the end of the intoxication period, a given animal might change his activity while maintaining the same posture—with the result that the behavior-posture relationship appeared dysjunctive and bizarre.

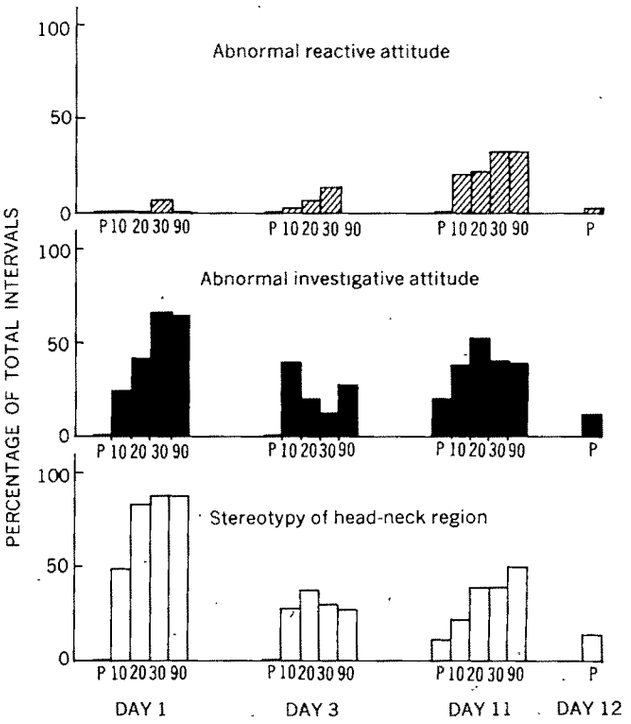
The last stage of intoxication was often characterized by akathisia-like repositioning and stepping movements that had the same agitated starting-and-stopping quality frequently noted in psychiatric patients with more chronic extrapyramidal manifestations induced by neuroleptic drugs. Toward the last day of the two-week study period many animals showed transient or adventitious movements that appeared to have little or no relationship to the main vector of behavior and that at times appeared incongruent to the overall behavioral configuration. The composite picture was one of hyperkinesia, in which the gradual breakdown of organized behavior accompanied an abnormally aroused and often fearful state.

DISCUSSION

Similarities Between Experimental and Clinical Amphetamine Intoxication

We have attempted to relate the progressive stages of chronic amphetamine intoxication in animals to the evolving stages of behavioral psychopathology observed in human amphetamine abusers. Because of their cognitive-perceptual nature, the symptoms most eminently related to the evolving paranoid psychosis are difficult to correlate directly with behavioral manifestations in lower animals. Remarkable similarities do exist, however, and in general it appears that the evolution of behavior in animal models is in many ways analogous to that noted in human patients. Table 1 presents our triple-layered

FIGURE 2
*Relationship Between Attitudes and Stereotypy During the Course of Amphetamine Intoxication**



*Each bar represents the occurrence of the behavior in a three-minute observation period on the indicated day during the preinjection period (P) or at ten, 20, 30, or 90 minutes after injection.

TABLE 1

Triple-Layered Analysis of Chronic Amphetamine Intoxication as a Model of Functional Paranoid Psychosis

Category	Early Stages	Intermediate Stages	End Stages
Functional paranoid psychosis	Paranoid tendencies		Paranoid psychosis
Human model psychosis (chronic amphetamine intoxication)	Curiosity: repetitious examining, searching, sorting behavior	Sustained pleasurable suspiciousness: looking for meanings, minutiae	Ideas of reference; persecutory delusions and hallucinations: fearful, panic-stricken, agitated, overreactive
Animal model psychosis (chronic amphetamine intoxication)	Abnormal investigatory attitude with repetitious activity	Restricted repetitious activity	Reactive attitude

model, in which amphetamine psychosis serves as a model of functional paranoid psychosis, and chronic intoxication studies in animals serve as a behavioral model of amphetamine psychosis.

The activities of many amphetamine abusers demonstrate a remarkable resemblance to patterns of examining behavior seen in animals. For example, amphetamine-induced repetitive "grooming behavior" in human addicts is not unlike that noted in rhesus monkeys. Usually it is manifested as incessant examining, rubbing, and picking (using the forefinger probe and pincer grasp), which often result in raw blemishes and in scars. Individual patients observed through a one-way screen sometimes spend hours examining and probing visually accessible parts of the body (9).

These same behaviors demonstrate the importance of the time dimension in the formation of delusions through the gradual organization of behavior, thought, and feeling about these acute experiences. Many patients who demonstrate grooming behavior, for example, develop marked delusions of parasitosis and spend many hours examining their skin and digging out imagined parasites. These delusions appear to develop out of early sequences of skin sensations and repetitive "grooming responses." Thus, in both man and lower animals, sequences of patterned behavior, such as the grooming response, take on an autonomy and centrality of their own. In man, the next step is the gradual cognitive development of a corresponding entrenched and stereotyped delusion (1).

Although he did not recognize the common mechanisms underlying automatic-compulsive behaviors and stereotyped expressions, Bleuler (14) listed a variety of repetitive behaviors that he called stereotypies. In these he included posture, movement, attitude, and thinking. He even mentioned stereotypies of drawing, music, writing, and speech (verbigeration). Bleuler considered these constrained modes of behavior most characteristic of catatonic schizophrenia, but he noted that they were also present in other forms of schizophrenia, including the paranoid type. We have previously discussed the many features that paranoid and catatonic schizophrenia have in common and their relationship to the amphetamine psychosis (7).

We have pointed out that a common attitudinal-postural mechanism may subserve both the motor stereotypies and the constricted perceptual and cognitive patterns (7, 15). We conceive of these postural mechanisms not as passive responses providing orientation in space but more as a vigorous outgoing behavior that is acting on and projecting sensorimotor apparatus onto the environment or as reaching out and selecting parts of space and objects to be seen, felt, and thought about. Qualitatively the nature of these mechanisms might fall somewhere between posture, attitude, and initiation of movement. These mechanisms could well initiate and coordinate the many modes of perceptual attention, including searching and orientation to the outside world; conversely, these mechanisms may direct attention between various external as well as internal cognitive sets.

An amphetamine-induced loss of initiative or distortion of the mechanisms that regulate the continuous flow of behavior is postulated as the factor underlying not only stereotypies but also the perseveration of perceptual-cognitive-attitudinal sets. Thus we found in our cats fixing of attention and attitudes as well as fixing of posture and patterned movements. In other words, the animal's attentive mechanisms are persistently directed to a certain aspect or part of the environment, even after the accompanying stereotypy has broken. These fixed attitudes are not unlike those observed in speed freaks who become "hung up" for hours, either on a puzzle or in examining-sorting compulsions, or in suspicious, repetitious scanning movements of the eyes. Thus, a marked tendency to maintain attitudinal sets, as well as the accompanying examining modes, is characteristic of chronic amphetamine intoxication in both man and animals.

By the same mechanism, thinking itself could become repetitious as a result of perseveration in one of the systems subserving perception and cognition. For example, it is possible that stimulation of a specific postural-attitudinal set might not only induce the motor components of grooming behavior but also tend to constrict perception toward the enhancement of minute objects and, in this way, potentiate the associated thinking process that leads to the delusion of parasitosis. By an analogous process, the scope of the all-pervasive attitude of curiosity and/or suspiciousness that characterizes incipient

paranoid schizophrenia or the beginning phase of amphetamine psychosis might become increasingly constricted until, under the influence of behavioral disorganization, increasing arousal, and/or fear, the individual's behavior evolves into a paranoid reaction.

Neurochemical Basis for Amphetamine-Induced Behaviors

Over the past several years there have been exciting developments in research attempting to fractionate the types of behavior induced by amphetamine intoxication and to ascertain which behavioral neurotransmitters mediate these specific behaviors. It has been demonstrated that amphetamine-induced release of the neurotransmitter dopamine, which is densely distributed throughout the nigro-neostriatal system (16, 17), is responsible for the stereotyped behavior (18–20), while norepinephrine mediates the amphetamine-induced hypermotility. The nigro-neostriatal dopamine system is known to have a marked effect on the postural and motor mechanisms associated with attention—a finding that is in keeping with the amphetamine-induced behavior observed in animals as well as in man.

Recent studies on animals with unilateral, lesion-induced degeneration of the nigro-neostriatal dopamine system have demonstrated that when L-dopa or amphetamine is administered to these animals there is spontaneous turning of the head to the side of the lesion and neglect of sensory stimuli or searching behavior on the contralateral side (21). In addition, McKenzie (22) has demonstrated that bilateral ablation of the olfactory tubercle in rats markedly reduces the sniffing stereotypy induced by stimulation of the dopamine receptors. The projection of the dopamine terminals into the olfactory tubercle (23)—the old motor nucleus of the olfactory brain—also fits well with the observation that amphetamine stimulates postural changes and head movements related to olfactory searching in macrosmatic animals.

Functionally there are additional indications that the rhinencephalic forebrain is mediating the type of behavior induced by amphetamine (15). Electrical stimulation of the pyriform cortex, the olfactory tubercle, the amygdala, and the insulo-orbital cortex produces various oral exploratory activities, such as rhythmic sniffing, gnawing, and licking movements (24). In man similar automatisms and rhythmical movements are accompanied by characteristic changes in consciousness in the course of psychomotor epileptic seizures. We have previously reported (15) that there is a dramatic similarity between the psychosis associated with temporal lobe epilepsy and amphetamine psychosis. Recently we have demonstrated that, following the blockade of norepinephrine synthesis, amphetamine induces a dramatic increase in rhinencephalic electrical activity, with subsequent seizures (25). More importantly, this catecholamine manipulation produces behaviors (e.g., reactive attitude) that are seen only at the end stages of chronic amphetamine intoxication.

In addition, it is now well known that haloperidol and pimozide, two drugs that primarily block dopamine receptors (26), are two of the most effective antipsychotic agents currently in use. Angrist and associates (27) have also demonstrated that d-amphetamine is only one to two times as potent as l-amphetamine in producing psychosis although the ratio of potency is 10:1 for other effects. This potency ratio for the elicitation of psychosis is quite consistent with the hypothesis of stimulation through dopaminergic mechanisms since there are similar dose-response relationships in producing experimental animal stereotypy (28) and in changing the comparative kinetics of the accumulation of norepinephrine and dopamine at synaptasomes (29).

Fuxe and Ungerstedt (30) have previously demonstrated that amphetamine-induced behavior is related not only to the type of catecholamine neurotransmitter activity, but also to the ratio of norepinephrine to dopamine. By appropriately blocking and stimulating norepinephrine and dopamine mechanisms, they demonstrated that a strong norepinephrine-to-dopamine ratio is associated with exploratory locomotor behavior; when the ratio is reversed, an exploratory stereotypy is produced. When norepinephrine is depleted and, in addition, dopamine activity is enhanced by the administration of L-dopa, the exploratory stereotypy becomes highly constricted and compulsive. Gunne and Lewander (31) have demonstrated that *acute* amphetamine intoxication in animals primarily depletes norepinephrine, whereas *chronic* amphetamine intoxication depletes both norepinephrine and (to a lesser degree) dopamine.

When both norepinephrine and dopamine are depleted, important behavioral effects are induced through loss of the righting reflexes (32), and the catecholamine receptors become supersensitive to such receptor stimulants as apomorphine (21). Thus catecholamine depletion may be quite important in setting the stage for a supersensitive response to amphetamine. It may be that the depletion of norepinephrine and/or dopamine, as well as the disturbance of the balance between the two neurotransmitters, may have so sensitized the catecholamine neurons that additional amphetamine stimulation produces the hyperreactive state observed in our cats both in the later stages of chronic amphetamine intoxication and following the blockade of norepinephrine synthesis.

In conclusion, it is important that the amphetamine psychosis be regarded as an *evolving* sequence of behaviors that appears in several stages and cannot be explained on the basis of a single neurotransmitter effect. The physiological as well as the behavioral state is qualitatively different in the various stages of chronic amphetamine intoxication. Thus, in the model psychosis based on chronic amphetamine intoxication, the effect of the drug in further stimulating the altered psychological state of an animal resulting from previous intoxication, as well as stimulating depleted supersensitive norepinephrine and/or dopamine neuronal systems, is qualitatively different from the effect of the drug on a naïve animal. This line of reasoning is consistent with our thesis that each evolving behavioral state of amphetamine psychosis provides a base for the subsequent manifestation of the psychosis.

REFERENCES

1. Ellinwood EH Jr: Amphetamine psychosis: a multidimensional process. Seminars in Psychiatry 1:208–226, 1969
2. Ellinwood EH Jr: Amphetamine psychosis, I: description of the individuals and process. J Nerv Ment Dis 144:273–283, 1967
3. Rylander G: Preludin-narkomener fran linish och medicinsk-krimin olgisk synpundt. Svenska Lakarticha 63:973–980, 1966
4. Scher J: Patterns and profiles of addiction and drug abuse. Arch Gen Psychiatry 15:539–551, 1966
5. Kramer JC, Fischman VS, Littlefield DC: Amphetamine abuse: patterns and effects of high doses taken intravenously. JAMA 201:305–309, 1967
6. Doyle AC: The sign of the four, in The Annotated Sherlock Holmes. Edited by Baring-Gould WS. New York, Clarkson N Potter, 1967, vol 1, pp 610–688
7. Ellinwood EH Jr, Sudilovsky A: Chronic amphetamine intoxication: behavioral model of psychoses, in Psychopathology and Psychopharmacology. Edited by Cole JO, Freedman AM, Friedhoff AJ. Baltimore, Johns Hopkins University Press, 1972, pp 51–70
8. Ellinwood EH Jr, Escalante O: Chronic amphetamine effect on the olfactory forebrain. Biol Psychiatry 2:189–203, 1970
9. Ellinwood EH Jr: Effects of chronic methamphetamine intoxication in rhesus monkeys. Biol Psychiatry 3:25–32, 1971
10. Ellinwood EH Jr, Escalante O: Chronic methamphetamine intoxication in three species of experimental animals, in Current Concepts of Amphetamine Abuse. Edited by Ellinwood EH Jr, Cohen S. Washington, DC, US Government Printing Office, 1973, pp 59–68
11. Ellinwood EH Jr, Sudilovsky A, Nelson L: Behavioral analysis of chronic amphetamine intoxication. Biol Psychiatry 4:215–230, 1972
12. Randrup A, Munkvad I, Ulsen P: Adrenergic mechanisms and amphetamine-induced abnormal behavior. Acta Pharmacol 20:145–167, 1963
13. Randrup A, Munkvad I: Stereotyped activities produced by amphetamine in several animal species and man. Psychopharmacologia 11:300–310, 1967
14. Bleuler E: Textbook of Psychiatry. New York, Macmillan, 1924
15. Ellinwood EH Jr: Amphetamine psychosis, II: theoretical implications. Int J Neuropsychiatry 4:45–54, 1968
16. Anden NE, Dahlstrom A, Fuxe K, et al: Further evidence for the presence of nigro-neostriatal dopamine neurons in the rat. Am J Anat 116:329–333, 1965
17. Fuxe K, Hokfelt T: Catecholamines in the hypothalamus and pituitary glands, in Frontiers of Endocrinology. Edited by Ganong WF, Martini L. New York, Oxford University Press, 1969, pp 47–96
18. Randrup A, Scheel-kruger J: Diethyldithiocarbonnate and amphetamine stereotyped behavior. J Pharm Pharmacol 18:752–760, 1966
19. Fog RL, Randrup A, Pakkenberg H: Adrenergic mechanisms in corpus striatum and amphetamine-induced stereotyped behavior. Psychopharmacologia 11:179–183, 1967
20. Ernst AM, Smelik PG: Site of action of dopamine and apomorphine on compulsive gnawing behavior in rats. Experientia 22:837–845, 1966
21. Ungerstedt R: 6-hydroxy-dopamine-induced degeneration of central motor neurons. Eur J Pharmacol 5:107–110, 1968
22. McKenzie GM: Role of the tuberculum olfactorium in the rat. Psychopharmacologia 23:212–220, 1972
23. Escalante O, Ellinwood EH: Depletion of biogenic amines and enhancement of cholinergic activity in the olfactory bulb and central olfactory connections with chronic methedrine intoxication. Arquivos de Neuropsiquiatria 28(2):110–117, 1970
24. Monnier M: Functions of the nervous system, in General Physiology, Autonomic Functions. Edited by Monnier M. New York, Elsevier Publishing Co, 1968, pp 251–278
25. Ellinwood EH Jr, Sudilovsky A, Grabowy R: Olfactory forebrain seizures induced by methamphetamine and disulfiram. Biol Psychiatry (in press)
26. Janssen PAJ, Fernand TNA: Pimozide, a chemically novel, highly potent and orally long-acting neuroleptic drug. Arzneim Forsch 18:279–284, 1968
27. Angrist BM, Shopsin B, Gershon S: Comparative psychotomimetic effects of stereoisomers of amphetamine. Nature 234:152–153, 1971
28. Taylor KM, Snyder SH: Amphetamine: differentiation by d and l isomers of behavior involving brain norepinephrine or dopamine. Science 168:1487–1489, 1970
29. Snyder SH, Taylor KM, Coyle JT, et al: The role of dopamine in behavioral regulation and the actions of psychotropic drugs. Am J Psychiatry 127:199–207, 1970
30. Fuxe K, Ungerstedt U: Histochemical, biochemical, and functional studies on central monoamine neurons after acute and chronic amphetamine administration, in Proceedings of the Mario Negri Institute for Pharmacological Research. Edited by Costa E, Garattini S. New York, Raven Press, 1970, pp 277–288
31. Gunne E, Lewander T: Long-term effects of some dependence-producing drugs on the brain monoamines, in Molecular Basis of Some Aspects of Mental Activity. Edited by Wahaas O. New York, Academic Press, 1967, vol 2, pp 75–81
32. Ellinwood EH Jr, Escalante O: Behavior and histopathological findings during chronic methedrine intoxication. Biol Psychiatry 2:27–29, 1970

The Dream-Protein Hypothesis

BY ERNEST LAWRENCE ROSSI, PH.D.

Recent studies of learning and memory indicate that new experience is encoded by means of protein synthesis in brain tissue. The author reviews the literature on diet, nutrition, dreams, and REM sleep and finds support for the hypothesis that dreaming is a process of psychophysiological growth that involves the synthesis or modification of protein structures in the brain and that serves as the organic basis for new developments in the personality. The author outlines a series of experiments to further test the validity of this hypothesis. The implications of this research for a "growth" or "psychosynthetic" orientation in psychotherapy are discussed.

RECENT RESEARCH in the biology of learning and memory typified by the work of Hyden (1) indicates that new learning and behavior are encoded in the synthesis and/or modification of protein structures in brain cells. This statement of the relationship between biochemical events (protein synthesis) and behavior (new learning) is sufficient for behavior therapy but the language of psychodynamic psychotherapy requires the inclusion of phenomenological events. The relationship between phenomenological events and behavior is explored by the traditional methods of psychiatry and psychology (clinical interview, psychodiagnostic testing, etc.) but thus far the relationship between biochemistry and such events as dreams and fantasies has received little theoretical formulation or empirical support. This suggests the need for a dream-protein hypothesis: dreaming is a process of psychophysiological growth whereby dramas played out on a phenomenological level involve the corresponding synthesis and/or modification of proteins in the brain; this synthesis serves as the organic basis for new developments in the personality.

Studies that support the dream-protein hypothesis can be drawn from the vast body of research that uses rapid eye movements (REM) as the index of dreaming. These involve both the relationship between protein synthesis and dreaming and the relationship between dreaming and new developments in the personality.

Dr. Rossi is Extension Instructor, Department of Social Sciences, University of California at Los Angeles, and an analyst at the C.G. Jung Institute of Los Angeles; his address is 10486 Santa Monica Blvd., Los Angeles, Calif. 90025.

The author wishes to acknowledge the assistance of Ms. Jo Ann Boorkman, Computer Search Analyst, UCLA Information and Biographical Service Section, in obtaining a portion of the references for this paper through MEDLARS Computer Search no. 101726/R001, which was subsidized by the National Library of Medicine.

PROTEIN SYNTHESIS AND DREAMING

A MEDLARS computer search covering the research literature from January 1969 through June 1972 on the relationship of diet and nutrition to dreams and REM sleep yielded 181 citations, of which about 20 percent dealt with the relationship between protein synthesis and dreaming. The most direct evidence for this relationship in humans is the finding that alterations in protein metabolism achieved by either blocking or supplementing amino acids in the diet has an effect on dreaming. It has been found by Lester and colleagues (2), for example, that low-phenyl-alanine-tyrosine diets result in a systematic reduction in REM sleep. They then found this effect could be reversed so that the percentage of REM sleep was increased when tyrosine (in capsule form) was added to the diet. Furthermore, it has been found by other investigators (3) that tryptophane has a small but statistically significant effect in increasing REM sleep. The deprivation or supplementation of amino acids that are associated with ribonucleic acid (RNA) and protein synthesis is thus directly related to REM sleep in humans.

Our literature search turned up many more references to experimental work with animals than with humans. The general finding documented by numerous animal studies (4–7) supports the finding of the studies with humans, i.e., that deprivation or supplementation of amino acids in the diet results in corresponding effects on REM sleep. In no case, however, was there a study designed specifically to evaluate this relationship. Most of the studies were motivated by interest in the neurochemical origin of REM sleep, the role of amino acids in the transmission of the nervous impulse, or the action of monoamine oxidase inhibitors on REM sleep, rather than by the concept embodied in the dream-protein hypothesis. Although the results of these studies are all in the direction that would be predicted by the dream-protein hypothesis, new studies specifically designed to test the validity of the hypothesis are now called for. Three general approaches to validating the dream-protein hypothesis seem possible.

1. In table 1, the three-stage process in the synthesis of proteins from amino acids and RNA is outlined, together with a listing of some of the metabolites and chemical agents that have been used (8, 9) to facilitate or retard each stage in learning and memory experiments. In general the dream-protein hypothesis would predict that agents that facilitate any stage of protein synthesis would tend to increase REM sleep, while those agents which block a stage of protein synthesis should decrease REM sleep. This prediction has been amply verified at the

amino acid stage but not at stages closer to the synthesis of RNA and proteins. Such verification would be needed to further confirm or disprove the dream-protein hypothesis.

2. During the past decade, innovations in biochemical analysis that permit the isolation and measurement of extremely small amounts of macromolecular RNA, of such enzymes as cholinesterase (10), and of neural growth factors (11) have enabled researchers to determine how these substances affect memory and learning. In essence these studies indicate that new developments in learning and behavior may be associated with changes in the synthesis and/or structure of RNA. If researchers can now detect changes in the presence of RNA, cholinesterase, or neural growth factors at the locus of dream activity (e.g., the visual cortex) during the REM state, they will have provided further support for the dream-protein hypothesis.

3. The relationship between protein intake and dreaming has been more difficult to describe. Although extreme protein deprivation does result in EEG abnormalities (2), I have not yet found any studies dealing directly with the relationship between the deprivation of protein or protein precursors (apart from the amino acid studies cited above) and REM sleep. Three types of research could clarify this relationship: 1) neuroanthropological studies of the effect of extreme protein deprivation on the REM sleep of population groups that are subject to these specific types of malnutrition (12); 2) REM studies on people who subject themselves to macrobiotic diets that are deficient in proteins (my preliminary interviews with a number of such people yielded the expected subjective report of decreased dreaming or dream recall while they were on such diets); and 3) animal studies that relate protein and amino acid deprivation to REM sleep (13).

TABLE 1
Agents That Have Been Used to Facilitate or Block Protein Synthesis

Item	Increase Uptake or Synthesis	Block Uptake or Synthesis
Amino Acids	Dietary amino acids: tryptophan, tyrosine, etc.	Amino acids restricted
RNA	Yeast RNA, malononitrile, magnesium pemoline (?), soluble RNA	8-azaquanine, actinomycine-D
Protein	Dietary proteins, malononitrile (dimers and trimers)	Restricted diets, puromycin, puromycin amino nucleoside, cycloheximide

DREAMS AND PERSONALITY DEVELOPMENT

Just as Snyder (14) has organized many of the diverse and apparently unrelated findings of REM research into an evolutionary theory of dreaming on the phylogenetic level, we may also apply the findings of much REM-related research to the ontogenetic development of the individual's personality. I shall summarize those findings which bear upon the integrative or psychosynthetic functions of REM sleep that are most directly relevant to the dream-protein hypothesis.

1. Dreaming is initiated and primarily regulated by internal brain processes rather than by external stimuli from the environment (15). That is, dreaming is a process that is important for internal developments within the brain itself rather than for handling external stimuli. In an evolutionary theory of dreaming, Snyder expressed this conception well:

> [The REM state] is not a condition of partial arousal intermediate between sleep and waking, but now appears to be among the most extraordinarily intense activations yet discovered in the normal functioning of the central nervous system. Although similar in many respects to highly aroused waking, there are good reasons for thinking that the functional organization of central nervous activity is quite different from waking, and that the stimulus which originates this activation is intrinsic to the brain itself (14, p. 123).

Meissner (16) has outlined the neurophysiological mechanisms characteristic of REM activation that "suggest that the striking activation of limbic structures in rhombencephalic sleep has a specific integrative function which serves to maintain the effective organization and integration of emotional and cognitive experience." The conclusion therefore seems inescapable: the state of dream consciousness concerns the organization and synthesis of internal data (e.g., personality development), while the awake state of consciousness deals primarily with the processing of external sensory data from the environment.

2. The REM state occupies up to 50 percent of the sleep time of neonates and children (at ages when learning and personality formation is greatest) and then decreases to 20 to 25 percent with increased age, as the capacity for new learning and personality growth becomes relatively less (17).

3. Recent studies (18) of the dreams of children and adolescents indicate that the typical dreams of normal children revolve about recreational activities and as such "appear most simply to represent extensions of the child's waking ego impulses to exploration and manipulation of the environment." The REM state can thus be understood as a period during which internal programs are being synthesized and consolidated so they can later be actualized in personality and behavior change.

4. Dement and associates (19) have recently summarized findings from their laboratory which demonstrate that REM sleep is necessary for the optimal control and integration of drive systems (aggression and sex) in laboratory animals even though it is not necessary for life itself. Recently Hartmann and his co-workers (20) have concluded from studies with humans that "psychic pain or psychic disequilibrium with changing defense patterns" are associated with an increase in REM sleep. The

subject who required more REM sleep "is relatively anxious and depressed, and his life style involves change and worry." These conclusions are exactly what one would expect if dreams had a psychosynthetic function in maintaining the growth and stability of the ego, since more REM sleep would be required during periods of more active personality growth, change, and stress.

5. Recent studies of the correlation between REM sleep and the process of change in psychotherapy provide interesting confirmation for the above. Freedman and associates (21), for example, reported that "striking and consistent correlations were discovered between the length of the fourth dream period and the [psychotherapy] session variables of self-satisfaction, wish fulfillment, elation, and control." I have discussed elsewhere how these types of variables can be understood as indications that a process of psychological growth (psychosynthesis) is taking place (22). This type of study thus tends to confirm that there is a direct relationship between dreaming and personality growth as stipulated by the dream-protein hypothesis.

PSYCHOTHERAPEUTIC IMPLICATIONS

Validation of the dream-protein hypothesis would provide a biological basis for modern theories of personality change, growth, and development. Most workers have been so overwhelmed by Freud's concept of psychoanalysis that they have tended to overlook psychosynthetic processes. Just as the biochemical basis of life may be conveniently divided into anabolic and catabolic processes, so one may posit a dynamic equilibrium within the phenomenological realm between psychosynthetic processes (whereby entirely new and more complex psychological experiences are created) and analytic processes (whereby a breakdown of inner experience into simpler parts is evident).

The growth or psychosynthetic orientation is actually the common denominator of a very wide range of the apparently diverse "schools" of psychotherapy that have developed since Freud (23). Apart from the ideas of such early ego psychologists in the Freudian psychoanalytic framework as Hartmann, Kris, and Lowenfeld, Jung's central concept of individuation, Adler's concept of the creative self, and Rank's emphasis on the artist-type may all be understood as efforts to explore the synthetic or creative aspects of personality development. The existential approaches of Binswanger, May, and Frankl emphasize the complex coping methods by which a person actually creates his existence and world view. In recent years the client-centered, humanistic, and gestalt psychologists have all elaborated approaches and attitudes toward psychotherapy that focus on a growth orientation.

While the growth orientation frequently has been presented in a global and loosely defined manner by many of these theorists, the psychosynthetic approach of Assagioli (24) and the autogenic meditation methods of Schultz and Luthe (25) have introduced a certain degree of precision and scientific control in facilitating personality development. Assagioli, for example, has pioneered in the development of "meditation" methods by which the patient allows his imagination to elaborate a standard series of emotionally significant patterns of internal imagery. This elaboration of internal imagery may have important diagnostic significance; more importantly, however, the growth-oriented therapist uses this approach to facilitate the actual synthesis of new psychic structures that can become the nuclei for new developments in the personality. I have recently extended this approach by illustrating in detail how symptoms of "psychopathology" can be understood as breakdowns in the natural processes of personality development (22). This analysis of these psychosynthetic processes, as outlined in a series of "phenomenological equations," suggests how they may be used to develop further approaches to facilitating personality development in psychotherapy.

The obvious drawback of the phenomenologically oriented growth approaches to psychotherapy is that they lack the foundation in biology and chemistry that most workers since Freud consider so important for any psychodynamic psychology. Concepts of libido, genetic determination, hormonal regulation, imprinting, and most of the other current variables of biological psychiatry are sometimes useful in dealing with the global or molar aspects of personality but they are obviously unable to account for the intricate variability found in individual fantasies and dreams that continually change with life experience. The dream-protein hypothesis is a means of directly relating these subjective events of personality growth to biochemical events. If the dream-protein hypothesis can be further validated it would be a major step in establishing a biochemical foundation for personality dynamics.

REFERENCES

1. Hyden H: The question of a molecular basis for the memory trace, in The Biology of Memory. Edited by Pribram K, Broadbent D. New York, Academic Press, 1970, pp 101–119
2. Lester B, Chanes R, Condit P: A clinical syndrome and EEG-sleep changes associated with amino acid deprivation. Am J Psychiatry 126:185–190, 1969
3. Hartmann E: The pharmacology of dreaming sleep and its psychiatric implications, in The Psychodynamic Implications of the Physiological Studies on Dreams. Edited by Madow L, Snow L. Springfield, Ill, Charles C Thomas, 1970, pp 47–70
4. Karadzic V, Micic D, Rakic L: Alterations of free amino acid concentrations in cat brain induced by rapid eye movement sleep deprivation. Experientia 27:509–511, 1971
5. Davis J, Himwich W, Stout M: Cerebral amino acids during deprivation of paradoxical sleep. Biol Psychiatry 1:387–390, 1969
6. Francesconi R, Mager M: Effects of sleep deprivation on the periodicity of tyrosine metabolism in mice. Experientia 27:1273–1274, 1971
7. Haulica I, Ababei L, Teodorescu C, et al: The influence of deprivation of paradoxical sleep on cerebral ammonia metabolism. J Neurochem 17:823–826, 1970
8. Gurowitz E: The Molecular Basis of Memory. Englewood Cliffs, NJ, Prentice-Hall, 1969
9. Gaito J (ed): Macromolecules and Behavior, 2nd ed. New York, Appleton-Century-Crofts, 1972
10. Krech D, Rosenzweig M, Bennett E: Chemical and anatomical

plasticity of the brain. Science 146:610–619, 1964
11. Levi-Montalcini R: Growth control of nerve cells by a protein factor and its anti-serum. Science 143:105–110, 1964
12. Stoch M, Smythe P: Undernutrition during infancy and subsequent brain growth and intellectual development, in Malnutrition, Learning, and Behavior. Edited by Scrimshaw N, Gordon J. Cambridge, Mass, MIT Press, 1968, pp 278–289
13. Gordon M, Deanin G: Mitochondria and lysosomes: a proposal on the protein nutrition of the synapse. Ibid, pp 136–150
14. Snyder F: Toward an evolutionary theory of dreaming. Am J Psychiatry 123:121–136, 1966
15. Dement W: An essay on dreams: the role of physiology in understanding their nature, in New Directions in Psychology, vol 2. Edited by Barron F. New York, Holt, Rinehart, and Winston, 1965, pp 93–114
16. Meissner W: Dreaming as process. Int J Psychoanal 49:63–79, 1968
17. Roffwarg H, Muzio J, Dement W: Ontogenetic development of the human sleep-dream cycle. Science 152:604–609, 1966
18. Foulkes D, Larson J, Rardin M: Two studies of childhood dreaming. Am J Orthopsychiatry 39:627–643, 1969
19. Dement W, Cohen H, Ferguson J, et al: A sleep researcher's odyssey: the function and clinical significance of REM sleep, in The Psychodynamic Implications of the Physiological Studies on Dreams. Edited by Madow L, Snow L. Springfield, Ill, Charles C Thomas, 1970, pp 71–123
20. Hartmann E, Baekeland F, Zwilling G, et al: Sleep need: how much and what kind? Am J Psychiatry 127:1001–1008, 1971
21. Freedman A, Luborsky L, Harvey R: Dream time (REM) and psychotherapy. Arch Gen Psychiatry 22:33–39, 1970
22. Rossi E: Dreams and the Growth of Personality. New York, Pergamon Press, 1972
23. Rossi E: Game and growth: two dimensions of our psychotherapeutic zeitgeist. Journal of Humanist Psychology 7:139–154, 1967
24. Assagioli R: Psychosynthesis: A Manual of Principles and Techniques. New York, Hobbs Durman, 1965
25. Schultz J, Luthe W: Autogenic Therapy, vol 1. New York, Grune & Stratton, 1969

The Manfred S. Guttmacher Award

The American Psychiatric Association invites applications for its annual Manfred S. Guttmacher Award for 1974. The award is given for any outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or any other work, including audiovisual presentations, submitted to or presented at any professional meeting or published during the year ending December 31, 1973. The award, which includes an honorarium of $250 and a plaque, will be presented at the Convocation of Fellows at the annual meeting in Detroit, Mich., May 1974.

Anyone who wishes may apply to receive the award by submitting five copies of the work as well as five abstracts to Jonas Rappeport, M.D., Chairman, Guttmacher Award Board, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Entries will be acknowledged but will not be returned.

The deadline for submissions is January 1, 1974, and to be considered any entry must be in Washington by that date.

Indian Education: A Human Systems Analysis

BY CARL A. HAMMERSCHLAG, M.D., CLAYTON P. ALDERFER, PH.D., AND DAVID BERG, M.A.

The problems of Indian boarding schools are examined in the light of both systems theory and data from interviews and questionnaires conducted at one school. The authors conclude that the schools have failed to define their primary task—to educate or to handle children with behavior problems. More importantly, the impact of the whole educational system perpetuates the Indians' powerlessness and dependency on the government. The authors express the hope that, if there is more community involvement in the schools, this will lead to greater assumption of responsibility by Indians in other spheres.

THE BUREAU OF INDIAN AFFAIRS (BIA), charged with the education of American Indians, today operates more than 200 schools in 17 states. Of the approximately 200,000 school-age Indian children, 35,000 are in BIA boarding schools, 16,000 are in day schools, and 24,000 are housed in BIA dormitories while attending public schools. Of the 35,000 children in boarding schools, more than 12,000 attend off-reservation boarding schools, which for the most part provide a high school education for Indian children who have completed the eighth grade. The remainder are in on-reservation boarding schools; 8,000 of these are elementary school students, nine years old or under (1). Enrollment in BIA boarding schools is increasing; indeed, it has doubled in the 1960s.

The history of the boarding school experience, its inadequacies, and its archaicisms were first commented upon by Merriam in 1928 (2). Studies since have concluded that, as the cultural and educational backgrounds of Indian children become more like those of white children in public schools, the educational achievement of Indian children will more closely match that of white children (3–5). To many Indian people that implies a not very subtle attempt to sow the seeds of cultural dissolution, to use the schools as an instrument of Indian cultural annihilation. There are still rituals among tribes today to cleanse their children of white contamination on their return from boarding schools. This study explores the impact of a boarding school system on both students and staff members who live, learn, and work there.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Hammerschlag is Mental Health Consultant, Indian Health Service, 4212 North Sixteenth St., Phoenix, Ariz. 85016. At the time of this study, Dr. Alderfer and Mr. Berg were both with the Department of Administrative Sciences, Yale University, New Haven, Conn., where Dr. Alderfer is Associate Professor and Mr. Berg was a graduate student.

THE SCHOOL SYSTEM

The school studied, located in a major southwestern urban setting, has approximately 700 students, aged 14 to 22 years, and 200 staff members. All the students are Indians; most of the teaching and administrative personnel are non-Indian. At least 60 percent of the student body enters this boarding school for so-called "social reasons," which include extreme poverty, large families, language difficulties, and behavior problems in other schools. Because so many children come to the school for these reasons, there is considerable ambiguity among the staff as to whether the primary mission of the school is one of behavioral control or teaching.

For example, the dormitory attendants, who are charged with the management of 120 students per dorm, see their jobs as maintaining order and resolving immediate crises. The teaching staff see their roles as instructional, but students who do well in class are not necessarily the ones who also behave well outside the classroom. There is little interpenetration of the boundaries between these distinct task groups at any time. When it does occur, it usually concerns decisions about the dismissal of students with behavior problems. If the greatest articulation of structure exists for a secondary task of the system (such as behavioral control) and the purported primary task (i.e., education) remains isolated, the system is in trouble.

The concept of boundary is an aspect of open systems theory that treats organizations as systems whose survival requires the continuous exchange of materials with the environment (6–8). If the boundary is too permeable it invites inundation, chaos, and disorganization, whereas an impermeable boundary becomes a barrier that causes death through entropy. There are boundaries that separate the organization from its environment and those which are internal to the organization. These internal boundaries separate task systems from each other. The authority for these separate internal operations (dorm, teaching, guidance) is delegated by top management to subordinates. The viability of the subsystem, and ultimately of the total organization, is dependent on successful boundary transactions between these adjacent subsystems.

In the school's case, each subsystem functions as if it were totally independent and involved in tasks that are perceived as mutually exclusive. For example, a dormitory head telephoned a guidance counselor at midnight to say that a student was drunk and disorderly and asked that he come over right away. The counselor replied, "I don't think I can do much counseling with the student in

her condition." The dorm head exasperatedly shouted, "I want you here; I want you to see what we have to put up with," and then hung up the phone. The event is illustrative of a broader theme, one that has less to do with students and more with the feeling that each internal subsystem has little sensitivity to and understanding of what the other does.

The theme of impermeability of boundaries, expressed in issues like territoriality and insensitivity, occurs not only between adjacent subsystems but also internally within each task group—between dormitory heads who interpret and enforce restrictions differently ("I think the rules for boys' and girls' dorms should be different"), between academic departments ("This should be a vocational training center, not a college prep school"), and between each staff and its supervisor ("I don't know what the assistant principal in charge of my department is really supposed to do").

Finally, the boundaries between the school and the external environment (local community, Indian reservations, Washington, D.C.) affect and reinforce such internal organization perceptions. The external boundary regulation is much less delegatable than internal task functions, and it becomes the major task of top management. For example, the school's top management was recently confronted by pressure from the community and from Washington to keep children in school and was forced to make a decision to have proposed expulsions reviewed by a board including representatives from the tribe, family, school, and central office. The distances some of these representatives would have to travel makes such gatherings difficult, nor is there much agreement once they are convened. This has made it virtually impossible to obtain approval for expulsions. Since the internal task groups had used the threat and actuality of expulsion to enforce behavioral conformity, this policy on expulsions (in which the school itself had no input) removes whatever disciplinary power the task groups may have had. As within the internal subsystems, the exclusiveness and impermeability of boundaries results in isolation and resentment. Although it is said that all subsystems work toward one end, the basic theme—impenetrability, not working together, and failure to define tasks—is continually reinforced. By neglecting the boundary tasks and its role tasks, a system is produced that then tends to become, as will be seen, stagnant and incapable of growth.

METHOD

One of us (C.A.H.) was introduced as mental health consultant to the Phoenix Indian High School in July 1970 with the understanding that he would be spending approximately half his time there. He expressed his interest in children and desire to serve as an organizational consultant, as well as his hope and expectation that he would be able to work with the school community to define his role. As a way of getting to know more about the school and the issues people felt were important there, a series of in-depth interviews was conducted. A representative cross-section of all departments and students was seen and, with their consent, the interviews were recorded. The formally outlined interview included wide latitude for discussion of individual items of special relevance. On the basis of those interviews and subsequent replays, several general areas of concern became apparent. A questionnaire based on those shared concerns was developed so that the entire school community could respond to those commonly perceived problems. The questionnaire was distributed three weeks after the start of school; it was subsequently computerized and evaluated. These initial data were shared, discussed, and evaluated by the entire school during a two-day feedback session in March when formal classes were suspended.

To get some sense of what happened to people the longer they remained at the school, and to discover differing perceptions as a function of time within the system, the questionnaire was redistributed in the late spring of 1971. Similar data analyses were run and the results were compared. The main focus of this paper is the school as a social system, but the questionnaire data deal with individual attitudes. In interpreting the data, therefore, we have drawn from fieldwork talks, observations, and experiences to bridge the gap.

RESULTS

The BIA's guiding educational philosophy "encompasses the belief that all Indian children must have the opportunity to realize their full potential and to become useful members of society." It suggests that to facilitate ongoing and independent learning teachers should have access to widespread and well-organized materials and services. They should bend their energies toward developing attitudes of discovery, problem-solving research, and experimentation leading to creative and critical thinking.

Yet in spite of such expectations, considerable differences exist in terms of what people at the school think is being learned. In responding to the item "I use my abilities in my academic subjects," both students and teachers agreed that the longer they stay in school the less likely they are to use their abilities. Apparently something happens so that both students and teachers stop learning. There is also strong agreement between students and staff members that as one stays at the school one finds that it is really too easy to get passing grades. This raises the interesting possibility that both students and teachers may stop learning when they realize that no matter what happens in the classroom everyone passes anyway, thus removing the impetus for students to work and teachers to teach. In addition, students in the junior high grades feel that they are being well prepared for college, but those who remain to become upper classmen begin to share the staff's perception that they are being poorly prepared for college work (see table 1).

Replies to the item "Students who come here really don't want to learn" indicated that students and staff

TABLE 1
Responses to the Questionnaire Item "I Believe the Students Are Being Well Prepared for College Work" (in Percentages)

Group	Agree or Strongly Agree	Disagree or Strongly Disagree
Junior high students	63	9
Sophomore students	46	17
Junior students	30	32
Senior students	28	20
Academic teaching staff	0	76
Vocational teaching staff	0	75
Dormitory staff	5	52

members agreed (and more so as time goes on) that students do not really come to the school wanting to learn. Do students who remain at school to become upper classmen not want to learn, or do the students fulfull institutional or staff expectations that they cannot learn? Are students poorly prepared for college because they do not use their abilities or because the subjects are too easy?

Merton, in proposing the idea of the "self-fulfilling prophecy," stated that in many situations people tend to do what is expected of them. That phenomenon was recently vividly documented by Rosenthal and Jacobsen, who showed that student performance is affected by the teacher's expectations (9). The teacher who assumes that her/his students cannot learn discovers that she/he has a class of children who are indeed unable to learn; another teacher who makes the opposite assumption may discover she/he has a class of interested learners. (A similar process applies to other forms of behavior as well.) Charles Silberman, in *Crisis in the Classroom*, noted that "one cannot spend any substantial amount of time visiting ghetto schools, be they Black, Puerto Rican, Chicano or Indian, without being struck by the modesty of the expectations teachers, supervisors, principals and superintendents have for the students in their care" (10).

Using our own data to illustrate, is it possible that the students feel they do not come here to learn because, in spite of being at school, their teachers do not believe they are being well prepared? Teachers who give passing grades easily, but at the same time do not believe the grades reflect the child's ability or preparedness, are really saying the grade is not worth much; it is not a reflection of what the student does or ought to know. Doing well at the Indian school academically does not mean students will do well elsewhere. Indeed, it is the staff's expectation that they will not; the students know it, and they begin to believe that they are responsible for it. The school continues to have difficulty with dropouts, act-outs, and apathy because its students believe that it does not pay to achieve and do well in school. School holds a false promise: you can become all you want by learning, but no one believes you are learning.

It becomes clear in many ways that students and teachers talk to each other but do not really hear one another. Eighty percent of the students say that they often say things in their Indian language to annoy the teacher, but only 40 percent of the teachers perceive that it is happening at all. Students agree two or three times as often as staff members (and more so as the year goes on) that teachers are too old and have been here too long to be good teachers. The teaching staff too begin to agree with that perception as the year goes on. It is not only students who fulfill the teachers' expectations, but the reverse as well. The evidence suggests that the concept of the self-fulfilling prophecy ought to be expanded. Students and teachers seem to collude to develop negative expectations of each other, which each then proceeds to fulfull. The result is that neither teachers nor students develop; both

TABLE 2
Responses to Questionnaire Items on Indianness and Powerlessness (in Percentages)

Group	September 1970		March 1971	
	Agree or Strongly Agree	Disagree or Strongly Disagree	Agree or Strongly Agree	Disagree or Strongly Disagree
"It is impossible for a non-Indian to appreciate what it means to be an Indian."				
Indian students	64	11	58	10
Indian staff members	46	34	70	18
Non-Indian staff members	29	40	29	30
"No matter what I do or say, nothing will ever change here."				
Indian students	32	25	35	21
Indian staff members*	26	35	71	14
One year			60	30
Two to four years			50	0
Five years			100	0
Non-Indian staff members*	21	47	34	31
One year			54	15
Two to four years			29	38
Five years			20	45

*The figures below refer to number of years these persons had been employed at the school.

TABLE 3
Responses to Questionnaire Items on Interest and Involvement in the School (in Percentages)

Group	September 1970		March 1971	
	Agree or Strongly Agree	Disagree or Strongly Disagree	Agree or Strongly Agree	Disagree or Strongly Disagree
"If I could, I would send my children to school here."				
Indian students	36	23	28	32
Indian staff members	23	52	13	75
Non-Indian staff members	19	71	14	72
"The most important things in my life involve the school."				
Indian students	65	11	64	9
Indian staff members	67	17	30	39
Non-Indian staff members	30	32	31	34

become estranged, do not use their full abilities, and fail to grow and perform together.

INDIANNESS AND POWERLESSNESS

All who were interviewed seemed to agree that whether one is or is not an Indian made a difference in terms of one's experience at the school. Although all people at the school agreed that their respect for Indian heritage and tradition increases as a result of being there, it is difficult in some ways to translate such respectfulness into objective terms. It is the Indian student or staff member who hears, with far greater frequency, insulting things being said about Indian people. The saying of such things and the hearing of them increases as the school year goes on.

Indian students and staff members agreed about twice as often as the non-Indian staff that "it is impossible for a non-Indian to appreciate what it means to be an Indian" (table 2). Most striking is the fact that it is the Indian staff, even more than the students, who, as time passes in the school, perceive their Indianness as something that separates, distances, and devalues them. It is they who are most disenfranchised and powerless within the system.

Much has already been written and said about the uninvolvement and powerlessness that students feel and experience in school settings (11–14). They are uninvolved in the one-way learning street, where teachers reveal the proper, orderly, laddered acquisition of facts in an unenthusiastic way. Less emphasis has been placed on the fact that in many ways school staff members mirror the students' feelings. In this school, it is the Indian staff member who perceives himself as the least able to change things, the least in control, and the most disaffected (table 2). It is the Indian staff member who changes most dramatically with time; the longer the staff members remain at the school, the less likely they are to describe themselves as able to change things. They feel increasingly powerless (table 2). The converse is true for non-Indian employees who, as they spend more time in the system, see themselves as more able to change things at the school.

Such perceived powerlessness leads to disaffection. On the item "If I could I would send my children to school here," the responses of the Indian staff members changed most dramatically as the year went on; they became the group least likely to send their children to this school by the time school ends (table 3). Similarly, it was the Indian staff who changed most dramatically in terms of their involvement in the school (table 3).

Slightly more than half of the BIA's 160,000 employees are Indian; most of these fill the lowest ranks (janitors, aides, drivers, laborers, secretaries); 80 percent of the better jobs are held by non-Indians. Even in nonprofessional areas, Indians for the most part are not in supervisory roles and they are the ones who are most dependent upon the system since they have the fewest realistic options for work elsewhere. Even students, who may be ruled, restricted, and structured, know that their time at school will end. Indian staff members are a captive audience who, because of their lack of proper credentials and thus salable skills, may stay indefinitely. And it is not the staying that is painful but the sense that even though they stay nothing will change. In the face of such a dilemma, one becomes disaffected, disenchanted, and dissatisfied, but rather than act out these feelings (which students sometimes do), Indian staff members tend to become apathetic and unfeeling.

CONCLUSIONS

Although there have been reforms in Indian education, the schools themselves remain far less effective than is desirable. The BIA's educational goals emphasize a system in which people share and grow and a setting in which student and teacher share what one wants to know and the other wants to teach, in which there is less submission to an obligatory curriculum and a greater number of options, and in which there is less emphasis on externally applied controls and more on one's responsibility for

one's own behavior. Simultaneously, however, the boarding school invites those with "behavior problems which cannot be solved by families or existing facilities" and who can "benefit from the controlled environment of a boarding school." It cannot do both.

By accepting students for "social reasons" it implies that it can deal with them in some way. It has not and, because it has not, it demoralizes both teacher and student. In accepting the role of agent of social control, the school overreaches its resources, leaving precious little time for scholarly endeavors. Since they are unable to deal with students who act out and drop out, the staff members begin to wonder what they are doing here; they eventually withdraw and simply survive from day to day.

In systems terms, the school fails to define its primary task. The subsystems operate as if they exist only to serve their individual ends. Their inability to articulate, to make their boundaries more permeable, and together to more clearly define the primary task is expressed in frustration, powerlessness, and ennui.

Interestingly, the school is being asked to deal with problems that are based on a 100-year history of paternalism and its concomitant tribal dependency. The more the school accepts the charge of dealing with "problem" children, the more it deemphasizes the real need for it to be dealt with elsewhere, by parents and by the tribes themselves. It is the people who can and must assume some power in determining their futures rather than abandon that responsibility to others. Since the system has, for a century, forced and encouraged such dependency, any self-steering behavior has become difficult. But the more the school permits itself to be used as an institution for control, the more it reemphasizes and tacitly encourages the tribes not to deal with it. The *giving* of education, like the giving of health and welfare, destroys people by robbing them of their own sense of powerfulness and worth. It reemphasizes the institution's ability to give and the people's need to receive; it thus recreates a master-slave syndrome (15).

This is clearly a long way from a simple discussion of Indian education. Yet if the concern is with education one cannot restrict one's observations only to the schools. To study Indian education means to study Indian history and American society and to understand that the difficulty in the education of Indian children lies as much with a society that has degraded and disenfranchised Indian people for more than a century as it lies with the teachers, students, and schools.

The recommendations offered so far have included making the off-reservation boarding schools into residential treatment facilities for seriously disturbed Indian children. It has also been suggested that personnel be increased, that there be more representative and involved school boards, and that parents become more involved in the establishment of the curriculum. In the face of massive tribally perceived powerlessness and institutional entrenchment, these solutions, as they relate to existing boarding schools, are trivial. The boarding schools are ineffective educationally and they are ineffective as agents and enforcers of social control. They perpetuate, by mere virtue of their existence, the myth that they can educate and control better than parents and communities can. Most importantly, by being available they remove the impetus for those issues to be dealt with directly by the tribes themselves. The answer must lie in public education, with active community involvement in all aspects of decision making. Such an excercise in visible power would serve as a model for the assumption of similar responsibilities in other spheres of reservation life. From the limited context of schools, perhaps we can begin to minimize the rampant institutional dependence that pervades most tribes.

REFERENCES

1. Havinghurst RJ, Birchard B: National Study of Indian Education, vol 2: Education of American Indians. Chicago, University of Chicago Press, 1970
2. Merriam L: Problems of Indian Administration. Baltimore, Johns Hopkins University Press, 1928
3. Peterson SA: How Well Are Indian Children Educated? Washington, DC, US Indian Service, Department of the Interior, 1948
4. Anderson KE, Collister EG, Ladd CE: The Educational Achievement of Indian Children. Washington, DC, Bureau of Indian Affairs, Department of the Interior, 1953
5. Coombs LM: The Indian Child Goes to School. Washington, DC. Bureau of Indian Affairs, Department of the Interior, 1958
6. Newton PM, Levinson DJ: The work group within the organization: a sociopsychological approach. Psychiatry 36:115–142, 1973
7. Miller EJ, Rice AK: Systems of Organization. London, Tavistock, 1967
8. Katz D, Kahn R: The Social Psychology of Organizations. New York, John Wiley & Sons, 1965
9. Rosenthal R, Jacobsen L: Pygmalion in the Classroom. New York, Holt, Rinehart & Winston, 1968
10. Silberman CE: Crisis in the Classroom. New York, Random House, 1970
11. Kohl H: Thirty-Six Children. New York, New American Library, 1967
12. Friedenberg EF: Coming of Age in America. New York, Random House, 1965
13. Kozol J: Death at an Early Age. New York, Houghton Mifflin, 1967
14. Illich I: De-Schooling Society. New York, Harper & Row, 1971
15. Hammerschlag CA: Pride, powerlessness, and rebellion: the red and the black. Journal of Human Relations 18:656–669, 1970

The Eclectic Approach to the Treatment of Phobias

BY K. ROY MACKENZIE, M.D.

A patient with air travel phobia was treated by a variety of therapeutic techniques. Initially, intensive reciprocal inhibition similar to implosion therapy was used, with concomitant supportive psychotherapy. Then psychodynamically oriented short-term therapy was introduced to achieve more lasting results. The author suggests that rather than establishing a dogmatic position in terms of selected technique, the therapist should take a truly eclectic approach within the unfolding treatment of a single patient.

TECHNIQUES of behavior modification based on learning theory have been increasingly used by psychiatrists in recent years. This has been particularly true in the treatment of phobias. Most psychiatric residency programs include behavior therapy training in their curriculum and emphasize the need for eclecticism in the choice of treatment modality.

Despite these trends the choice of a behavior therapy program is often accompanied by a lingering regret that more "respectable" psychotherapeutic principles could not be used. On occasion, the decision to use behavioral approaches is accompanied by the requirement for referral to a specialized practitioner or by the downgrading of the status of the patient. These attitudes imply to the patient that he is being abandoned to the vagaries of a new and dubious therapeutic modality and that if it does not work he can always return to the tried and tested halls of traditional psychotherapy.

This paper suggests that the truly eclectic practitioner will be prepared to incorporate different treatment modalities within the confines of treatment of a single patient. The following case report and discussion center around the use of concepts borrowed from implosion therapy, reciprocal inhibition, supportive psychotherapy, and brief psychodynamic psychotherapy.

CASE REPORT

A 50-year-old professional man presented himself for treatment with an increasing level of anxiety that was reaching almost intolerable proportions. His anxiety revolved around a proposed trip to Europe in two weeks. He had almost decided to cancel the trip despite the disappointment it would mean for his wife and children.

For many years the patient had enjoyed flying and had even done considerable flying in small planes with friends who were recreational pilots. Six years prior to this visit he had been at a professional convention in a distant city and had developed first a sore throat and then a peritonsillar abscess. He deferred obtaining treatment there, and on the three-hour plane flight home he noted the rapid onset of laryngeal edema, which produced early symptoms of obstruction of the airway. He was aware of the possible implications of this condition and became severely anxious.

Since that time he had felt marked apprehension over taking an airplane flight. He had taken flights on two occasions, under great duress and with marked anxiety, but had canceled numerous trips at the last minute because he could not face the prospect of entering the plane. He had flown most recently about 18 months prior to his present illness but had felt so much anxiety while away that he terminated his visit and returned prematurely.

His specific fear of flying had generalized to a concern that he would not know where qualified medical services were available. When discussing a proposed flight, he talked of airports where emergency landings could be made and of his knowledge of hospitals and physicians along the route. The degree of his anxiety was directly related to the distance traveled. A trip of 75 miles would produce definite anxiety, but a trip of 200 miles would probably be canceled. A 500-mile trip would precipitate a major crisis, and anything beyond that would hardly be countenanced. While the patient was away from home the slightest physical symptom, such as a dry throat, would trigger an anxiety state over impending illness.

He had promised his family the European trip in a moment of impulse, feeling that perhaps by having a definite objective he would overcome his fears. He had come to regard his phobia as a sign of weakness and incompetence that was seriously undermining his previously healthy sense of self-confidence. He felt that he would be incapable of handling an unexpected or crisis situation and therefore would have to suffer the loss of respect of his family.

A detailed history did not reveal evidence of major psychopathology in other areas of his life. His work demanded intense, limited concentration. He became annoyed at minor delays and inefficiencies in his staff, but these characteristics had made him an effective worker, and he was regarded as a well-qualified person in his profession. He was happily married and had a satisfactory sexual adjustment. His four children, who ranged in age from 13 to 22, were adjusting satisfactorily, although his oldest son tended to be overly compulsive about his studies and was somewhat insecure over his progress despite achieving superior grades. These characteristics were similar to those of the patient when he had been a student. The patient had always found it difficult to relax from his work and tended to place himself under unnecessary responsibilities. He had not been one to take

Based on a paper read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972. The original title of this paper was "Behavior Therapy Versus Psychotherapy in Phobias."

Dr. MacKenzie is Associate Professor of Psychiatry, University of Calgary Medical School, and Director of Psychiatry, Holy Cross Hospital, 2210 2nd St., S.W., Calgary, Alberta, Canada.

vacations and when he did so usually wanted to get back to make sure everything was operating satisfactorily at the office. Despite this, he had a good relationship with his four children and had an active social life with many friends.

The patient was given 5 mg. of diazepam orally at the beginning of the initial treatment session, which lasted three hours. Relaxation exercises were used. The patient proved adept at these, and a light hypnotic trance was easily induced. A process of hierarchical desensitization was undertaken. He was asked to imagine scenes in the following sequence: taking a short trip with his family in the countryside a few miles from the city, taking a longer trip to a resort community 90 miles away, driving past the airport, driving into the airport and sitting in the lounge, sitting in the passenger waiting area, boarding the plane and looking around, sitting in an airplane seat, feeling the plane move down the runway, taking a short commuter flight lasting half an hour, taking a longer flight to a city one hour away, and finally, taking the proposed overseas trip. The session ended with a posthypnotic suggestion that the patient relax while seated in an airplane.

The patient was then instructed to go to the airport directly from the office and take a 25-minute commuter flight to a nearby city. He was instructed to call me from the terminal at the other end and report his progress, which he did. He took an immediate return flight and again called me upon his arrival. During both phases of this trip he was able to relax and experienced little anxiety.

The patient was seen on four other occasions over the subsequent two weeks. He was able to keep his anxiety under control through a combination of posthypnotic suggestion, the use of a relaxation tape, and 5 mg. of diazepam three or four times daily. Five days prior to departure a minor crisis occurred when he received word that he had some income tax arrears to pay. He pleaded that this would be a major financial burden and that he would not be able to finance his European trip. Since there was an element of validity to the argument, despite his use of it for psychodynamic ends, it was suggested that the family have a meeting to discuss the situation and that they should in any case make an extended trip, even if not overseas. Two days later he returned to say that he had found himself increasingly annoyed at capitulating to his anxiety. He had decided to obtain a loan to finance the trip. He was clearly in much better control and was occupied with the realistic problems of preparation for the trip. His oldest son was seen and given a brief description of the self-reinforcing nature of phobias and of the need for firmness and support if the patient's anxiety should pose a problem while the family was away.

The patient experienced minor tension during the flight to Europe but found that after landing his anxiety rapidly diminished and that the five weeks of his vacation were among the most relaxed and enjoyable he had spent for many years. The flight home was relaxed, and he experienced no tension. Toward the end of the vacation one of his children developed a gastrointestinal upset with a high fever and chills, but the patient handled the situation calmly and made appropriate arrangements.

When seen on his return the patient reported his pride at accomplishing this feat and his feeling that the whole exercise had served to rekindle his self-confidence. During this interview I chose to emphasize the need for a reassessment of the patient's life-style. He was encouraged to plan more breaks in his business routine and to get away with his wife and family. He was able to discuss with understanding his preoccupation with vocational performance and relate it to his long years of vigorous training. He established some definite goals to discuss with his wife in terms of mutual recreational plans.

When the patient was seen again six weeks later these plans were reviewed and definite progress was noted. He was planning to attend a professional convention in two weeks. The thought of this trip was producing minor anxiety, but he anticipated no difficulty in managing it. A phone call on his return confirmed that the experience had been successful. A 12-month follow-up visit revealed that he had successfully pursued his intent of establishing a more balanced life-style. He had made several other trips alone and with his wife and was attending more concerts, plays, etc., than he had for many years. He was relaxed and felt more at ease with himself and was satisfied with his progress.

DISCUSSION

The management of this patient involved a variety of therapeutic modalities. The basic initial treatment approach was that of reciprocal inhibition and desensitization, as described by Wolpe (1). This was applied in an extremely concentrated and intense fashion. The entire hierarchy of nine items was covered in a single prolonged interview with virtually no pause between progressions. Satisfactory relaxation was achieved through the use of a small dose of a minor tranquilizer, relaxation exercises, and the induction of a light hypnotic trance. Posthypnotic suggestion was also used.

Rather than allowing a random application of the material covered during reciprocal inhibition, a specific task was assigned immediately following the therapy session. Thus therapeutic use was made of the impetus built up during the long initial session. By making a plane flight without significant anxiety, the patient demonstrated to himself in dramatic fashion that he was able to break through his phobia of flying. This single session together with its assignment virtually eliminated the phobia component to the presenting symptoms. Subsequently, the patient expressed little anxiety concerning airplanes or flying per se. A rapid removal of this component allowed the future sessions to deal with the patient's more general concern about being away from home, away from medical resources, and unable to deal with crises.

The intensive application of reciprocal inhibition and desensitization has some correlation to implosion therapy as initially described by Stampfl and Levis (2, 3). This technique has been clinically applied by a number of workers, notably Hogan, Kirchner, Levis and Carrera, and Hodgson and Rachman (4–10). The technique attempts to create intense anxiety in the office situation through the process of imagining the feared object or situation. The subject is encouraged to repeatedly immerse himself in the threatening scene and to experience the extent of the physiologic anxiety equivalents. By performing this repeatedly, the intensity of the reaction gradually subsides. Stampfl and Levis explain that "the emphasis is not upon the acceptance of interpretations, but rather upon the extinction of anxiety-evoking conditioned stimuli (cues) which provide both motivational and reinforcing properties for perpetuating the patient's symptoms (avoidance responses)" (3). The clinical reports in the literature, however, are far from convincing. Many deal with presumably well-functioning students with a specific phobia of snakes or rats. The application

of these findings to clinical cases is problematic. Other studies rely exclusively upon inadequate measures of improvement, such as shifts in scales in the Minnesota Multiphasic Personality Inventory.

On a theoretical basis, there is a fundamental difference between implosion therapy and reciprocal inhibition. The former argues that if intense emotional reactions occur in the absence of primary reinforcement, extinction of neurotic behavior patterns that were learned and perpetuated by anxiety will occur. The latter therapy is based on the concept that two opposing states, anxiety and relaxation, cannot coexist. The two therapies begin, as it were, at opposite ends of the stimulus hierarchy.

However, the methods used in the treatment of this patient have from a practical, if not a theoretical, standpoint considerable similarity to implosion therapy—namely, the prolonged immersion of the patient in feared fantasies. There is some similarity to the negative practice technique in which the subject is instructed to practice the target response deliberately and repeatedly (i.e., tics). It is theorized that stable relationships between stimulus and response are interrupted because the response is being deliberately emitted under all sorts of stimulus conditions. More recently, Suinn and Hall have reported on short-term intensive desensitization procedures with both individuals and groups (11, 12). Implosion therapy, negative practice, and the intense application of reciprocal inhibition all use massed practice.

The general principles of supportive psychotherapy were heavily utilized during the initial therapy period of this patient. These involved the use of moderate doses of a minor tranquilizer, my verbally expressed expectations for the outcome of treatment, and my reassurance and availability (for example, when the patient's phobia was specifically challenged during his commuter plane flight). The use of a relaxation tape allows the patient immediate access to the therapist's voice in times of stress and thus provides emotional support in addition to the physiologic effects of relaxation. Dependence on the therapist was encouraged as a time-limited device to assist in the resolution of the crisis situation. By my insistence that the feared activity be actually consummated in a real-life situation, however, the patient was able to prove to himself that he could master his fears and thus could demonstrate his independence from the therapist. This interpretation was encouraged.

It is important to acknowledge the role of supportive psychotherapy during the application of behavioral modification techniques. Treatment results may be seriously altered by the presence or absence of a purposely cultivated positive therapeutic relationship.

At the time of first contact the patient was in a state of emotional decompensation characterized by anxiety, a sense of futility, and a diminished sense of self-esteem. He demonstrated considerable dependence on me, including unrealistic expectations of my power and abilities. However, in the two sessions following the patient's return from Europe, short-term psychotherapeutic principles were used, and his dependence was specifically curtailed.

Throughout his adult life this patient had functioned adequately in vocational, social, and family areas. This was his first episode of significant emotional decompensation. Rather than encouraging a reconstruction of childhood experiences and early family relationships, I chose to interpret to the patient his pattern of excessive devotion to work and his difficulty in accommodating personal needs for recreation and family activity. This was presented as a common difficulty for professional people. The patient readily acknowledged this pattern.

He was encouraged to use his effective organizational skills in the specific task of planning alterations in his life-style. His recent successful vacation plus a strongly positive transference relationship ensured motivation for this task. By translating personality conflicts into specific behavioral goals, they are rendered more concrete. Focusing on a specific issue is frequently necessary in the context of short-term psychotherapy, in the expectation that more widespread changes will occur following an initial shift. During the posttrip period the patient used me as a resource as he focused on the issues of his compulsive work-oriented life-style, and he has attempted to alter it. The encouragement of time-limited dependency is a useful (perhaps inevitable) tool in crisis situations. As this patient's symptoms subsided, the issue of dependency and its resolution was clearly discussed. There is evidence to suggest that the brief therapeutic content in this case (eight sessions) proved useful not only in dealing with a specific phobic crisis but also in promoting a reevaluation of life-style and the inauguration of effective changes.

The treatment of this patient demonstrates a natural sequence of therapeutic approaches. The presenting complaint of phobia of flying was handled through the intensive application of reciprocal inhibition. As this was resolved, more general concerns of availability of medical care and general self-confidence emerged. These were handled through relaxation exercises and supportive psychotherapy. These measures allowed the successful completion of the feared trip and laid the stage for the application of short-term psychotherapeutic measures. The latter were applied to a representative area of conflict and were objectified into behavioral goals. By dealing with specific symptoms initially, it was possible to eventually arrive at much more basic problems of life-style. An evolving therapeutic approach such as this is only possible if the therapist is familiar and comfortable with the application of a variety of therapeutic modalities. The treatment decision becomes not the choice of a technique for the patient, but rather the variety of techniques and the sequencing of their application.

REFERENCES

1. Wolpe J: Psychotherapy by Reciprocal Inhibition. Palo Alto, Calif, Stanford University Press, 1963
2. Stampfl TG, Levis DJ: Implosive therapy—a behavioral therapy? Behav Res Ther 6:31–36, 1968
3. Stampfl TG, Levis DJ: Essentials of implosive therapy: a learning-theory-based psychodynamic behavioral therapy. J Abnorm Psychol 72:496–503, 1967

4. Hogan R: The implosion technique. Behav Res Ther 6:423–431, 1968
5. Hogan RA, Kirchner JH: Implosive, eclectic verbal and bibliotherapy in the treatment of fears of snakes. Behav Res Ther 6:167–171, 1968
6. Levis DJ, Carrera R: Effects of ten hours of implosive therapy in the treatment of outpatients: a preliminary report. J Abnorm Psychol 62:504–508, 1967
7. Hodgson RJ, Rachman S: An experimental investigation of the implosion technique. Behav Res Ther 8:21–27, 1970
8. Hogan RA, Kirchner JH: Preliminary report of the extinction of learned fears via short-term implosive therapy. J Abnorm Psychol 72:106–109, 1967
9. Hogan RA: Implosive therapy in the short-term treatment of psychotics. Psychotherapy: Theory, Research, and Practice 3:25–32, 1966
10. Kirchner JH, Hogan RA: The therapist variable in the implosion of phobias. Psychotherapy: Theory, Research, and Practice 3:102–104, 1966
11. Suinn RM: Case histories and shorter communications. Behav Res Ther 8:383–384, 1970
12. Suinn RM, Hall R: Marathon desensitization groups: an innovative technique. Behav Res Ther 8:97–98, 1970

DISCUSSION

EUGENE M. CAFFEY, JR., M.D. (Bowie, Md.)—Dr. MacKenzie has presented a case report dealing with a most contemporary, and perhaps growing, problem: the fears aroused by traveling in airplanes. It has been said that such reports are the foundation of medical writing (1). As in this instance, the story of a patient-physician effort may also serve as a foundation for discussion of related matters. Dr. MacKenzie has incorporated a plea for eclecticism in therapy—to use whatever is necessary to help the patient (an ancient medical rule)—and some comments on behavioral modification approaches.

There is increasing awareness among those who study anxieties about flying and frank refusals to use air transportation that the deep interpretations of the meaning of flying often miss the mundane coincidence that sets the posture of apprehension. In this timorous traveler, who might have quite reasonably been avoiding a European excursion with a sizable family, we find the basic personality, described by Aronson, of those who fear flying: "Ambitious, hard-driving, successful people . . . are particularly likely to become anxious if they do not have things under control. These individuals abhor the passive role of the airline passenger" (2). Whatever these personality traits may betray of neuroticism, a key experience of this patient was of possible suffocation while far from help. The illustration fits well the statement of Rachman that:

> Human phobias are learned responses. They can be acquired by exposure to a single intensely painful or frightening situation, but are more probably acquired as a result of repeated exposures to sub-traumatic situations .... Like other neurotic reactions, phobias can be regarded as persistent, unadaptive reactions which are strongly colored by the subjective, autonomic and motor manifestations associated with anxiety (3).

What did Dr. MacKenzie do to help this handicapped mar who was so effective in most of his personal and public life? H crossed some boundaries and compounded a remedy from sev eral schools of therapy: psychotherapy (psychodynamic an supportive), behavior therapy (reciprocal inhibition and hierar chical desensitization), hypnosis, and pharmacotherapy, in a overall short-term treatment including, commendably, the ofte overlooked period of follow-up and opening up of more com fortable directions of living after the main symptom ha abated.

A major component of the treatment was that of desensi tization. As presented, the extended initial interview is an ex ample of a well-executed, classic Wolpe desensitization. It con tained little that was suggestive of the practice of implosiv therapy, however. I do not recall the author describing th heightening of the patient's anxiety and tension and fear by th efforts of the therapist, so vividly set forth by Hogan and Kirch ner (4). In keeping with Stampfl and Levis (5), I feel that th procedures used here and those of implosive therapies are both behavior therapies since they similarly rely on the learning an conditioning models of symptom origin and modification.

Regardless of the refinements of classification, it is inter esting to hear of the successful treatment of a sufferer of aviato phobia—a word that exists but is hard to find, unlike the situ ation it describes.

REFERENCES

1. Caffey EM Jr: Writing up research. Ment Hosp 14:163–166, 1963
2. Aronson M: How To Overcome Your Fear of Flying. New York Hawthorn Books, 1971, p 75
3. Rachman S: Phobias: Their Nature and Control. Springfield, Ill, Charles C Thomas, 1968, p 39
4. Hogan RA, Kirchner JH: Preliminary report of the extinction of learned fears via short-term implosive therapy. J Abnorm Psycho 72:106–109, 1967
5. Stampfl TG, Levis DJ: Essentials of implosive therapy: a learning-theory-based psychodynamic behavioral therapy. J Abnorm Psychol 72:496–503, 1967

A Study of Prediction and Outcome in a Mental Health Crisis Clinic

BY LOUIS A. GOTTSCHALK, M.D., RUTH A. FOX, M.D., AND DANIEL E. BATES

Sixty-eight patients who came voluntarily to a crisis intervention clinic were randomly assigned to one of two groups. Those in the first group received immediate intervention therapy while those in the second were put on a waiting list. By the end of six weeks (and after minor changes in the makeup of the groups were taken into account) there was no significant difference in the psychiatric morbidity scores of the two groups; both had improved. The authors used a variety of pretreatment and posttreatment measures and found that the best predictor of a patient's condition at the end of six weeks was his pretreatment psychiatric morbidity score. The authors conclude that individuals vary in both their reactions to life crises and their therapeutic needs and that the central issue may not be the recovery itself, but the difficulty and pain with which it is achieved.

WE UNDERTOOK THIS STUDY of patients who seek treatment at a mental health crisis clinic for several reasons: 1) to determine whether patients who receive brief crisis-oriented psychotherapy, with or without concomitant psychoactive drug therapy, show greater improvement in functioning than patients who are kept on a waiting list without immediate treatment; 2) to identify pretreatment variables that might serve as predictors of which patients will profit most from clinic treatment; and 3) to attempt to replicate the findings of a similar research study that had been undertaken previously in Cincinnati, Ohio (1).

METHOD

The subjects were patients who came voluntarily to the Mental Health Crisis Intervention Clinic, Orange County Medical Center, because of some life situation or emotional experience with which they had serious difficulty in coping.

To minimize observer bias, all patients were screened, evaluated on pretreatment, and posttreatment variables were evaluated by a member of the research team rather than by the treatment team. The following measures were used:

Content analysis scores derived from five-minute speech samples. At the beginning of a tape-recorded interview, the patients were asked to talk for five minutes about any interesting or dramatic life experiences they had ever had. From the typescripts of these speech samples, various psychological scores (Social Alienation-Personal Disorganization, Human Relations, Hope) were obtained by means of the Gottschalk-Gleser content analysis method, a measurement procedure for which satisfactory reliability and validity have been established (2). The Social Alienation-Personal Disorganization Scale is especially designed to distinguish schizoid trends and the schizophrenic syndrome, but it also functions effectively as a discriminator of general psychiatric morbidity (2). The Human Relations Scale measures the patient's current and typical desire for gratifying, supportive, and constructive human relationships (3). The Hope Scale measures the degree of optimism, sense of purpose in existence, and the positive outlook expressed by the subject (4). All five-minute speech samples were scored independently by content analysis technicians who had been trained to code speech according to the Gottschalk-Gleser method with high reliability and who were completely blind to the identity of the patients and the purpose of the study.

Psychiatric Morbidity Scale (PMS). A standardized psychiatric interview was tape-recorded. The interview was designed to elicit the current psychiatric symptoms and to establish the degree to which these psychiatric problems had disturbed the patient's typical functioning level. The patients were asked to talk about the problems that led to their coming to the clinic. They were specifically asked about current psychological symptoms, such as anxieties, depression, and fears; current behavioral signs, such as excessive drinking, not fulfilling family responsibilities, or crying; current interpersonal problems, such as withdrawal from or expression of anger toward people; and current somatic symptoms, such as cardiac palpitation, insomnia, or weakness. On the basis of a patient's responses, a psychiatric morbidity score was obtained by a method that has been described and tested elsewhere (1).

Approximately six weeks after the initial interview, we obtained another five-minute speech sample and a follow-up tape-recorded, standardized interview that were identical in format to the initial measures. The same interviewer took both sets of measures. The format of the interview and the PMS have been published recently in slightly modified form (5).

The authors are with the Department of Psychiatry and Human Behavior, College of Medicine, University of California at Irvine, Irvine, Calif. 92664, where Dr. Gottschalk is Professor and Chairman, Dr. Fox is Clinical Instructor, and Mr. Bates is Research Associate. Dr. Gottschalk is also Director, Psychiatric Services, Orange County Medical Center, Orange, Calif.

The authors wish to thank Gunnar Mazaroups, M.D., for his technical assistance and Herman Birch, Ph.D., for his statistical assistance.

The initial scoring of the interviews was done by the research interviewer. They were then rescored by a research associate who listened to the recordings but had no information on whether the patient had received immediate crisis intervention psychotherapy or had been asked to wait. The interrater reliability on the PMS for 92 interviews was 0.73 ($p<.001$), a level that indicates there was no observer bias. This high level of reliability and lack of observer bias indicates that this study approximated a single-blind design.

Ego strength and weakness scores. Paper and pencil tests and questionnaires were also administered to the patients when they came to the clinic. These included the Jacobs Ego Strength and Ego Weakness Scales (6), Barron Ego Strength Scale (7), and the Anant Belongingness Scale (8).

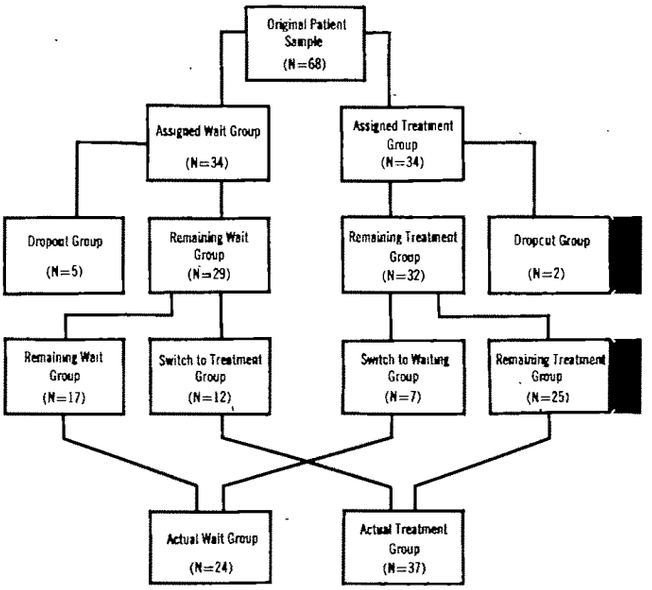
Embedded Figures Test scores. The relatively small number of patients who could cooperate were administered the Embedded Figures Test (9), a measure of field dependence-independence.

A patient who impressed the research interviewer as probably requiring immediate psychiatric hospitalization or as having serious medical problems was not accepted for this study. Only about eight percent of all patients coming to the crisis clinic fell into this category. The remaining patients were randomly assigned to either a therapy group (Assigned Treatment Group) or to a waiting-list group (Assigned Wait Group). Patients in the Assigned Wait Group were told that there were no immediate opportunities for them to receive psychiatric assistance, but that their names would be placed on a waiting list, which meant they would have to wait about six weeks to begin their treatment. Those who were in the Assigned Treatment Group received brief crisis psychotherapy within one hour of the initial evaluation and subsequently received from one to six treatment sessions from a psychiatrist, clinical psychologist, psychiatric social worker, or mental health associate. At the discretion of the psychiatrist who was consulted on the treatment plans for all patients, psychoactive medication was also prescribed for some patients. The crisis psychotherapy that was given to the patients was patterned after the crisis intervention treatment described by others (10–12).

RESULTS

On careful inquiry at the time of the follow-up interviews, we learned that a sizable number of patients initially assigned to the treatment group or to the waiting group (put on a waiting list) switched groups, that is, some of those who were in the treatment group did not appear for treatment and some of those who were in the waiting group obtained treatment elsewhere. The occurrence of these shifts from group to group and the number of dropouts (patients who failed to reappear at the clinic and could not be contacted in spite of strenuous efforts to do so) were recorded. The changes in the initial random assignments of the patients to a treatment or waiting list group are illustrated in figure 1.

FIGURE 1
Changes in Initial Assignments of Patients



Demographic Data

The average age of the entire sample of 68 patients was 32.01 years (standard deviation [S.D.] = 10.07); the average educational level was 11.54 grades (S.D. = 2.31). Eleven of the 68 patients were Mexican-Americans and the remainder were Caucasians. In the Hollingshead-Redlich two-factor classification system, none of the patients was in class I, three were in class II, 14 were in class III, 24 in IV, 16 in V, and 11 were not classified.

The Cincinnati sample (1) had a social class distribution that was very similar to that of our southern California sample, but the racial composition was different. Thirty-eight percent of the patients in the Cincinnati sample were black, while 16 percent of our California sample were Mexican-Americans.

Pretreatment Measures

After eliminating the dropouts, the Assigned Treatment Group and Assigned Wait Group were compared on the pretreatment measures using Student's t test. The differences in these scores were not significant.

All patients had been asked in the interview about their use of psychoactive drugs. After eliminating the dropouts, we compared the pretreatment scores of patients who had taken psychoactive drugs before treatment with those of patients who had not. The average Barron Ego Strength Scale scores were significantly lower ($t=2.16$, $p<.05$) for those who had been using psychoactive medications before treatment (16.90) than for those who had not (19.43). PMS scores and Embedded Figures scores tended to be higher and Hope scores to be lower for the patients who had been using psychoactive medications, but these differences were not significant.

Posttreatment Scores

The 37 patients in the Actual Treatment Group had an average of 2.7 treatment sessions (S.D. = 1.6), which ranged in duration from 20 to 50 minutes. We cannot assume that there is an absolute uniformity in the treatment over successive sessions because we are dealing with different therapists with varying skills spending varying periods of time with different patients. The Actual Treatment Group patients, however, definitely received more "treatment" than the patients in the Actual Wait Group, who received only the tape-recorded interviews.

An analysis of covariance[1] was performed on the posttreatment PMS scores, which were individually adjusted with reference to the pretreatment levels. Using a 2 × 2 × 2 × 2 factorial design, the patients were categorized by their actual conditions of treatment (Actual Treatment Group versus Actual Wait Group and psychoactive medication during treatment period versus no psychoactive medication during treatment period), by the experimental conditions they were assigned to (Assigned Treatment Group versus Assigned Wait Group), and by pretreatment drug use (users versus nonusers). We hoped that these last two categorizations would allow us to isolate subpopulations of the total experimental group and perhaps control for the self-selection into treatment conditions by the patients who switched groups. However, no significant differences or interactions were found.

A similar analysis of covariance was performed in which posttreatment Social Alienation-Personal Disorganization Scales were individually adjusted with reference to pretreatment levels. No significant differences or interactions were found.

Prediction of Outcome

On the basis of the correlations among various measures, a prediction equation for posttreatment Psychiatric Morbidity Scale scores (PMS_2) was obtained. The predictive pretreatment measures were the PMS scores (PMS_1), Social Alienation-Personal Disorganization Scale scores ($SAPD_1$), and Human Relations Scale scores (HRS_1). For the Actual Treatment Group (N = 33),[2] a multiple correlation of +0.62 was obtained; the prediction equation was $Z(PMS_2) = 0.506\ Z(PMS_1) - 0.237\ Z(HRS_1) - 0.007\ Z(SAPD_1)$. For the Actual Wait Group (N = 22), R = +0.57 and the prediction equation was $Z(PMS_2) = 0.408\ Z(PMS_1) + 0.049\ Z(HRS_1) + 0.340\ Z(SAPD_1)$.

These were the same variables that were found to have predictive value in an earlier and somewhat similar study conducted in Cincinnati (1). In that study too, the major predictive variable, the one that accounted for most of the multiple correlation, was the pretreatment Psychiatric Morbidity Scale (PMS_1). This meant that the more disturbed the patient was initially, the less favorable his outcome was six weeks or more later. The greater his initial interest in and motivation for satisfying human relationships (HRS_1) and the less his Social Alienation and Personal Disorganization ($SAPD_1$), the better the outcome six weeks later. (In the present study, however, these last two predictors were weaker than in the Cincinnati study.) In the Cincinnati study, the multiple correlation was +0.54 and the prediction equation was $Z(PMS_2) = 0.380\ Z(PMS_1) - 0.580\ Z(HRS_1) - 0.164\ Z(SAPD_1)$.

Simple inspection of the beta weights will show that there were some differences in the prediction formulas for the Actual Treatment and Actual Wait Groups that suggest that certain people are more likely to improve with crisis treatment than without it, although the average amount of improvement in the two groups showed no difference.

TABLE 1

Partial Correlations of Pretreatment Measures with Posttreatment Psychiatric Morbidity Scores (PMS_2)

Pretreatment Scores	Posttreatment Morbidity Scores (PMS_2)			
	Actual Treatment Group		Actual Wait Group	
	Correlation	N	Correlation	N
Social Alienation-Personal Disorganization	+0.16	35	+0.32	23
Human Relations	−0.26	35	−0.18	22
Hope	−0.03	35	+0.17	23
Jacobs Ego Strength	−0.10	32	−0.27	23
Jacobs Ego Weakness	+0.06	32	−0.08	23
Barron Ego Strength	+0.11	33	+0.02	24
PMS_1	+0.58	37	+0.46	24
Embedded Figures Test	+0.53	17	+0.18	17

Intercorrelations

Table 1 gives the partial correlations between the posttreatment PMS scores and eight pretreatment measures. The PMS_2 scores are corrected for correlation with the PMS_1 scores. The correlations for the Actual Treatment Group and Actual Wait Group tended to be in a similar range on all measures except the Embedded Figures Test (EFT_1). Table 1 shows that pretreatment Hope scores correlated significantly ($p < .05$) with greater change (improvement) in the Social Alienation-Personal Disorganization scores only for those patients in the Actual Treatment Group, and these same Hope scores correlated significantly ($p < .01$) with less change in Human Relations scores only for those patients in the Actual Wait Group. Also, the Embedded Figures Test scores correlated significantly ($p < .05$) with increases in Human Relations scores for the Actual Wait Group ($r = +.62$) but not for the Actual Treatment Group ($r = -.14$) among those patients for whom we were able to obtain Embedded Figures Test scores (table 2).

These findings again suggest that certain types of people may be more inclined to improve when receiving

[1] The analysis followed the general linear hypothesis model, using the BMDS64 program of Dixon (13) specifically.

[2] The multiple R could only be calculated for patients without missing scores.

TABLE 2
Correlations Between Pretreatment Scores and Difference Scores (Measures of Improvement)

Correlations*	Actual Treatment Group			Actual Wait Group		
	Correlation	N	Significance	Correlation	N	Significance
EFT_1 and (HRS_2–HRS_1)	–0.14	16	n.s.	+0.62	15	$p<.05$
Barron Ego $Strength_1$ and (PMS_2–PMS_1)	+0.37	33	n.s.	+0.24	23	n.s.
Jacobs Ego $Weakness_1$ and (PMS_2–PMS_1)	–0.28	32	n.s.	–0.13	22	n.s.
$Hope_1$ and ($SAPD_2$–$SAPD_1$)	+0.42	34	$p<.05$	+0.31	23	n.s.
PMS_1 and (PMS_2–PMS_1)	–0.65	37	$p<.01$	–0.55	23	$p<.01$
$Hope_1$ and (HRS_2–HRS_1)	–0.33	33	n.s.	–0.66	22	$p<.01$

*Abbreviations: EFT = Embedded Figures Test; HRS = Human Relations Scale; PMS = Psychiatric Morbidity Scale; SAPD = Social Alienation-Personal Disorganization Scale.

brief contact crisis treatment, while others, who are obliged to wait four to six weeks for such treatment, undergo some improvement with only the prospect of receiving treatment in the near future. On the other hand, in both groups, the sicker patients are likely ($p<.01$) to have less improvement, as indicated by the significant negative correlations ($r=-.65$ and $r=-.55$) between the pretreatment PMS scores (PMS_1) and the change occurring in such scores (PMS_2–PMS_1). These observed differences in the presumptive predictors of outcome in the Actual Treatment and Actual Wait Groups should, of course, be replicated in further studies.

DISCUSSION

Other investigators comparing treatment outcome in a treatment group versus a waiting list group have not mentioned switches of patients from one assigned group to another. The switches of patients from one of our originally randomly assigned groups to another makes us wonder whether our experience is unique or whether other investigators have simply failed to note and document such occurrences. This phenomenon, we suspect, is commonplace and poses an obstacle to securing randomly selected groups, a procedure that is necessary for making meaningful statistical comparisons between groups.

After seven patients dropped out, our remaining Assigned Wait Group patients manifested somewhat more psychiatric disability than our Assigned Treatment Group. Then, after some patients switched from one group to another, the Actual Treatment Group patients now had more dysfunction than the Actual Wait Group. This change appears to result from the high psychiatric morbidity of patients who switched from the Assigned Wait Group to the Actual Treatment Group.

Use of Pretreatment Psychoactive Medication

The fact that the crisis center patients who took psychoactive medication before treatment initially had significantly lower Barron Ego Strength scores and a stronger tendency to have higher PMS scores than other patients emphasizes that the use of pharmacologic agents, in itself, designates a subgroup of patients who are generally more incapacitated than other patients. That most of the patients taking psychoactive drugs did not receive these drugs by prescription from a physician but from "over-the-counter" sources or from relatives or friends suggests that this relative incapacity is not physician-induced. We cannot be certain whether lower ego strength or higher psychiatric morbidity is brought on by or precedes the use of psychoactive drugs, but we are inclined to believe that it precedes drug use.

We have found that patients who receive an average of 2.7 treatment sessions of 20 to 50 minutes each are improved, but no more improved at the end of six weeks than those who are still waiting for therapy. There are a number of possible explanations for these findings; we suspect that choosing among these alternatives will be influenced by whether one believes in the value of crisis intervention treatment. The alternatives include:

1. If a diagnostic and evaluative interview by a researcher who does not assume the role of a therapist is as effective as specific crisis intervention therapy carried out by a therapist, then it is the nonspecific aspects of the human relationship with a professional in the clinic that accounts for the improvement in the crisis patient's functioning six weeks after coming to the clinic. This conclusion would be a blow to those mental health professionals who assert that training in crisis intervention psychotherapy requires the inculcation of goals, techniques, and attitudes in the therapist. We find the hypothesis that crisis intervention therapy has specific, as well as nonspecific, features attractive, but more evidence is needed to support this view.

2. Crisis intervention may have been available in some form from friends and relatives outside the crisis clinic for the patients who were in the Actual Wait Group. This would account for the considerable improvement of these patients in six weeks.

3. Most patients suffering from life crises recover spontaneously within six weeks regardless of the kind of care they receive (10, 14). Klerman and Cole (15) also as-

erted that 50 to 60 percent of patients with acute depression and acute anxiety reactions recover within two to six weeks without receiving psychoactive drugs or any other form of treatment.

4. The analysis of covariance design, which adjusts for differences in initial (pretreatment) scores, may be statistically elegant but pragmatically inadequate; this procedure may not take into account important initial differences in the relative values of the pretreatment measures for our two groups.

5. The comparative amount of functional improvement in two groups of patients, each receiving different treatment programs, may not be the relevant issue; the central issue may be how much discomfort and suffering these patients had to undergo in the process of recovering from their crises. This issue was not addressed in this study.

Our study, at first glance, suggests the radical view that, with the exception of patients needing hospitalization, crisis intervention clinic patients may not need to be seen for specific crisis treatment since a diagnostic interview that is not focused on therapy may be of equal avail. We think that to hold such a view firmly is premature, but that our study has heuristic value in this connection. More credible is the notion that "naturally" reparative tendencies help people over life crises in a six-week period. Whether recovery is more comfortable and easier with crisis intervention is a different issue and may indeed be the essential difference in the experience of treated and waiting-list patients. We know, for instance, that minor surgery can be equally successful with or without anesthesia and that the healing rate of an infection is not appreciably influenced by an analgesic. But the suffering and pain experienced by patients in these situations is considerably reduced by an anesthetic or analgesic. Hence, this facet of treatment and outcome needs to be examined in evaluating the effectiveness of crisis intervention treatment as well as the comparative degree of functional improvement of the patient six weeks after coming to a crisis clinic.

Usually, crisis intervention aims at improving the coping mechanisms of patients so that they become more resilient in the face of later, similar life crises. Here again, our study did not examine this facet of outcome. We know of no controlled studies that have sought to demonstrate decisively that this important goal of crisis therapy has ever been attained; but we believe, on the basis of impressionistic longitudinal clinical observations, that experienced psychotherapists are capable of achieving such goals.

Prediction of Outcome

The prediction formulas for a favorable outcome for our two groups are similar to the prediction formula obtained in the earlier study with patients of approximately similar socioeconomic background in Cincinnati (1). The differences that exist between the two prediction formulas may be attributable to ethnic-racial differences in the two samples. Small differences in the beta weights of the prediction formula for our Actual Treatment and Actual Wait Groups and the correlation of the Embedded Figures scores with the outcome measures suggest that the people who improve with brief crisis therapy in our crisis center may be different from those who improve while waiting six weeks for such therapy (tables 1 and 2). If so, other investigators (16–18) who claim that there is very little functional difference between treated and waiting patients at the time of follow-up may be missing the differences in the types of people involved. It would appear that some patients have the capacity to respond favorably only with human interactions while others respond to stress with great resilience and respond very little, or even negatively, to specific human therapeutic intervention.

REFERENCES

1. Gottschalk LA, Mayerson P, Gottlieb A: Prediction and evaluation of outcome in an emergency brief psychotherapy clinic. J Nerv Ment Dis 144:77–96, 1967
2. Gottschalk LA, Gleser GC: The Measurement of Psychological States Through the Content Analysis of Verbal Behavior. Los Angeles, University of California Press, 1969
3. Gottschalk LA: Some applications of the psychoanalytic concept of object relatedness: preliminary studies on a human relations scale applicable to verbal samples. Compr Psychiatry 9:608–620, 1968
4. Gottschalk LA: A hope scale applicable to speech samples. Arch Gen Psychiatry (in press)
5. Gottschalk LA, Brown SB, Bruney EH, et al: An evaluation of a parents' group in a child-centered clinic. Psychiatry 36:157–171, 1973
6. Jacobs MA, Pugatch D, Spilken A: Ego strength and ego weakness. J Nerv Ment Dis 147:297–307, 1968
7. Barron F: An ego strength scale which predicts response to psychotherapy. J Consult Psychol 17:327–333, 1953
8. Anant SS: Belongingness, anxiety, and self-sufficiency. Psychol Rep 20:1137–1138, 1967
9. Witkin HA, Dyk RB, Faterson HF, et al: Psychological Differentiation. New York, John Wiley & Sons, 1962
10. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964
11. Bellak L, Leonard S: Emergency Psychotherapy and Brief Psychotherapy. New York, Grune & Stratton, 1965
12. Bergin AE, Garfield SL (eds): Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York, John Wiley & Sons, 1971
13. Dixon WJ: BMD Biomedical Computer Programs: X-Series Supplement. Los Angeles, University of California Press, 1969
14. Gottschalk LA: Some problems in the evaluation of the use of psychoactive drugs, with or without psychotherapy, in Psychopharmacology: A Review of Progress, Public Health Service Publication 1836. Edited by Efron DE, Cole JO, Levine J, et al. Washington, DC, US Government Printing Office, 1968, pp 255–269
15. Klerman GL, Cole JO: Clinical pharmacology of imipramine and related antidepressant compounds. Pharmacol Rev 17:101–141, 1965
16. Barron F, Leary TF: Changes in psychoneurotic patients with and without psychotherapy. J Consult Psychol 19:239–245, 1955
17. Goldstein AP: Patients' expectancies and nonspecific therapy as a basis for (un)spontaneous remission. J Clin Psychol 16:399–403, 1960
18. Endicott NA, Endicott J: "Improvement" in untreated psychiatric patients. Arch Gen Psychiatry 9:575–585, 1963

The Therapeutic Utilization of the Juvenile Court

BY YEHUDA NIR, M.D., AND RHODA CUTLER, PH.D.

The authors describe a collaborative program between an adolescent psychiatric clinic and a juvenile court that has resulted in the successful handling of otherwise untreatable court-referred adolescents. The approach used in this program has overcome two major problems in the therapy of adolescents: resistance to treatment and the tendency to act out. Court authority brings an abrupt halt to the chain of events perpetuated by the patients' behavior and at the same time intensifies the current crisis, thus making the patient more available for help.

THE CHANGES in the social and moral atmosphere of our times, the increased use of drugs, and the prominence of an adolescent subculture are being reflected in the number of acting-out delinquent adolescents in our society. Juvenile delinquency seems to increase in direct proportion to the complexity and prosperity of a society (1). The news media report numerous antisocial acts performed daily by young people, often in groups. They come from all social, religious, and economic strata and their number is constantly on the rise. During the period 1960–1970, the 10- to 17-year-old age group had a 25 percent population growth, while arrests in this age group increased by 113 percent. The increase in arrests in the over-18-year-old age group was only 16.9 percent (2).

Despite this significant increase in the incidence of juvenile delinquency, psychiatric treatment facilities remain limited, insufficient, and often ineffective. In an attempt to cope with this rise in delinquency, society resorts more and more to an authoritarian approach and, as a result, the burden of this major social problem falls on our legal system—or more specifically, on the juvenile courts.

This development has placed the juvenile court in a central position in relation to problems of today's "wayward youth." The court has become the emergency room for the psychiatric casualties of our adolescent population. In order to be able to cope with this new role, the courts have had to turn for assistance to the mental health profession, a relatively new development that places new responsibilities on the social workers, psychologists, and psychiatrists employed directly by the court or working with adolescents through other facilities. An exploration of court effectiveness in its new role, the interdisciplinary problems within the court, and the juvenile court's role in mental health are some of the many important issues facing those concerned with the problems of adolescents in our society.

Over the past few decades the juvenile courts have shifted their orientation from the judicial to the welfare approach and have therefore become increasingly interested in the rehabilitation of the adolescent delinquent. Moving away from the concept that punishment is effective either as retribution or as a deterrent has been one of the major factors in this shift.

Dunham (3) ascribed additional influences, such as the social-work orientation of the U.S. Children's Bureau, the broadening jurisdiction of the juvenile court; and prospects of treatment through the increased acceptance of psychoanalysis, which has provided techniques for getting at the roots of delinquency. In addition, there has been a continuing exploration in child development of the concepts of discipline and authority; attitudes have undergone many changes over the years. The Victorian strictness at the turn of the century, which was followed by the overpermissiveness of the twenties and thirties, was based on the false assumption that prevention of all possible frustrations would make the child immune to emotional disturbance. It became clear that permissiveness in and of itself is not therapeutic and that it is of value only within a definite setting. Experimentation with various methods resulted in the development of the concept of friendly understanding but limit-setting authority as the most effective way to deal with children.

Despite the fact that this issue is very important to educators, parents, legislators, and others, insufficient attention has been given to this concept. Outside the psychiatric profession there is still much confusion in the area of authority versus permissiveness, with the juvenile courts leaning heavily toward the latter. This might be a reaction to their past strict punitive approach—possibly a need to make it very obvious that a change is taking place. It is of interest that in two separate papers written in the forties, a judge, P.W. Alexander (4), compared the court to a hospital or clinic where the "sick" patient is diagnosed and treated, while A.C. Nutt (5), a social worker, stated that a juvenile court is primarily a court where legal responsibility is established specifically by law. Whatever the underlying causes, this situation puts

At the time this paper was written, Dr. Nir was Consulting Psychiatrist at the Jewish Board of Guardians, New York, N.Y. He and Dr. Cutler are now at Mt Sinai School of Medicine, where Dr. Nir is Assistant Clinical Professor and Dr. Cutler is Assistant Clinical Professor, and at Beth Israel Medical Center, 10 Nathan D. Perlman Pl., New York, N.Y. 10003, where Dr. Nir is Assistant Chief of Child Psychiatry and Dr. Cutler is Senior Psychologist.

The authors would like to acknowledge the invaluable advice and direction of Dr. Peter Blos in carrying out their work in the clinic.

©

the mental health practitioner who works with the courts in a paradoxical position. He finds himself recommending probation, placement, or confinement while the court tends to be lenient, to dismiss cases, or to adjust them at intake. Thus we see almost a reversal of roles and a potentially serious conflict that hampers the chances of the client, who is the real concern of both parties.

While many theoretical formulations have been advanced to explain the origin, nature, and prevention of juvenile delinquency, surprisingly little has been written since Aichhorn (6) and Makarenko (7) about specific therapeutic techniques, and insufficient validation of their effectiveness has been reported (8). Among the various alternate approaches reviewed, Empey and Raban (9) applied sociological theory to the treatment of delinquents. They viewed delinquency primarily as a group phenomenon and the task of rehabilitation as one of changing the shared delinquent characteristics. They considered peer-group interaction to be the principal rehabilitative tool and the primary source of help and support. Their program provided a type of social structure that permitted them to examine the role and legitimacy of authorities in the treatment system. Knight (10) reported that older, apparently more interpersonally responsive boys tended to be amenable to confrontative peer-group treatment and to be significantly more successful on parole than other subgroups released from his program.

Behavior modification techniques that utilize operant conditioning have been used to modify the behavior of institutionalized boys (11). However, further empirical study of the duration of these changes in community settings is needed. Alternate strategies have been proposed by others, whose efforts have been directed more toward integrating psychiatric services with probation departments and juvenile court services (12–14). Shoor and Speed (14) maintained that the concept that permissiveness is a sine qua non of mental health is erroneous and stressed that control and firmness may be therapeutic agents in the hands of experienced psychiatrists. They believed that the psychiatrist's role is to support the probation office, to treat cases when psychiatric elements are causative, and to demonstrate a respect for the law and legal processes.

Kaplan and associates (15) pointed out that since the psychotherapy of delinquents has been a disappointing experience in most clinics, probation (the circumstance under which most delinquents are referred) may be regarded as a method of stimulating greater ego control in lieu of the application of external control by incarceration. Compulsory psychotherapy as one condition of probation is therefore encouraged, with the probation officer continuing the same routine as he would without psychotherapy. The hypothesis of Kaplan's group is that the more the acting out by the delinquent can be prevented, the less likely it is for anxiety to be discharged in that way. They believed that the position of the therapist is to oppose the self-destructive impulses of the patient and to nurture ego-syntonic tendencies.

This paper describes the development of a collaborative approach between an adolescent clinic and a juvenile court that has resulted in the successful handling of otherwise untreatable court-referred adolescents. The Court Clinic of the Jewish Board of Guardians in New York City was established many years ago to serve Jewish adolescents who come to the attention of the juvenile court. The clinic's goal has been to offer psychiatric evaluation and treatment to those adolescents and their families whose presence in the court is the result of a psychiatric condition. From the legal point of view the adolescents fall into three categories: 1) juvenile delinquents; 2) persons in need of supervision (PINS); and 3) the subjects of neglect petitions. Their referral to the clinic, which is physically separate from the court, is either voluntary or required by a judge. A volunteer from the Jewish Board of Guardians, who is present daily in the juvenile court, facilitates the referral by describing to the family the nature of the service and its importance to the welfare of the child.

Initially the clinic's procedures were modeled after those of traditional child guidance clinics. Like Holmes (12), we perceived relatively early that very few cases materialized, that the number of broken appointments was very high, and that both the adolescents and their parents were reluctant to accept our services. It became apparent that the usual child guidance approach was ineffective because we were dealing with families in which acting out is an important modality in handling intrapsychic conflict (12, 15, 16).

Because of the complexity of the phenomena underlying acting-out behavior, we found it expedient at an early stage to deal with only one specific aspect of the problem, namely, the family's reluctance to accept our services. It became clear that our young patients were being used by their families to "act out the parent's poorly integrated and forbidden impulses" (17). The parents' resistance to treatment was an attempt to maintain the psychodynamic equilibrium of which the delinquent behavior of the youngster was an integral part, and a recommendation for psychotherapy or institutional placement had little chance of being accepted unless one could find leverages powerful enough to interrupt the tendency toward acting out. In dealing with a similar population at the Thom Clinic in Boston, Von Amerongen (18) found that acting out was for some of these families a family mode of instinct gratification. Describing fathers of those families, she wrote:

> Most of them were able to conform only to minimal and temporary diagnostic demands. Those whose wives and children went on with treatment after completion of the study have stayed away as much as possible. When summoned by us, some have appeared in body, but very few were able to reconsider their attitudes, and others categorically refused to come in, withdrawing increasingly from the family as work with mother and child progressed.

In dealing with the psychopathology of acting-out behavior, it is necessary to understand: 1) whether one is dealing with a real symptom that is the result of an intrapsychic elaboration of a conflict and, if so, where it is anchored within the psychic structure; 2) whether the be-

havior is a result of deficient ego defenses, i.e., breakdown of impulse controls in a psychotic or brain-damaged individual; 3) the role of the immediate and more peripheral environment in the presenting clinical picture; and 4) the intrapsychic and environmental modifications that can be attempted in order to deal effectively with these conditions.

The need to obtain information to clarify these points led us to expand the traditional diagnostic study to a much more extensive assessment. While this is obviously not a new approach to the study of the delinquent adolescent (19), we are stressing it because of the general tendency to deal primarily with the presenting symptoms of the delinquent adolescent rather than to study him in depth. A detailed assessment facilitates the development of an intervention strategy that relies on any one of the intrapsychic or environmental factors mentioned above for its main leverage. Thus we obtained information on the youngster's defensive structure, his stage of development along the continuum of the intrapsychic shifts of adolescence, the significance of his symptoms, and their possible reversibility.

We also gathered detailed information about the youngster's offense and all the events that surrounded it, including the reaction of the community, immediate neighborhood, school, church, etc. The response of the immediate and more distant family, the previous treatment record of the family, the court's prior attitude toward similar cases, the leanings and background of the judge assigned to the case, and the facilities available for carrying out our recommendations were also surveyed. The scope of this assessment has been highly influenced by the fact that we are dealing with adolescents who are in a fluid, rapidly shifting developmental stage, not yet encrusted with set psychopathology (20).

Although it is a demanding procedure, we have consistently attempted to gather this information in a relatively short period since we believe court-referred cases can be handled most effectively at the height of the crisis. A family whose child is apprehended after a delinquent act or who resorts to the use of the court to help control the youngster (a PINS petition) can be considered as being in a state of acute crisis. This is usually the time when tension rises to a climax and the individual and the family not only mobilize their own untapped resources but also tend to solicit help from others.

Since it has been demonstrated that during the emotional disequilibrium created by a crisis one is most susceptible to the influence of others (21), we have attempted to maximally utilize the therapeutic potential of the crisis.

For clarity of presentation, we shall consider the court-referred population as falling into three categories: 1) adolescents for whom court authority is used solely to contain their acting out while they remain in their own milieu; 2) those for whom court authority is used to facilitate placement in a therapeutic institution; 3) those who are intitially unmotivated but are able to become involved in outpatient psychotherapy through the support of court authority.

CASE REPORTS

The following case is characteristic of the first group of adolescents.

Case 1. Barry, 13 years old, illustrates the usefulness of court authority in helping an adolescent to control his surging sexual and aggressive drives. Barry was brought to court because he allegedly performed sodomy on a nine-year-old neighbor. He denied the charges and the court sent him for a psychiatric evaluation. Both he and his parents denied having any problems and saw no need for psychiatric treatment. In our assessment we found an isolated and affectively impoverished boy with paranoid thinking and a fear of being attacked (specifically, knifed). It was felt that Barry's acting out was a result of his uncontrolled aggressive impulses that were expressed sexually—a common pattern in a pubertal boy. He was diagnosed as suffering from a schizophrenic reaction, paranoid type; although psychotherapy and hospitalization were indicated the parents refused to cooperate.

Because of our conviction that Barry was too disturbed not to be in treatment we recommended indefinite probation, subject to periodic reviews, on the assumption that external controls would strengthen Barry's ego defenses and enable him to contain the erupting sexualized aggressive impulses. Although our recommendation was accepted by the court only with reluctance, Barry was placed on probation and remained on it for a year. His behavior during that time was asymptomatic and he was doing well in school. As a result of continuous pressure from the probation department to terminate probation because of his good behavior, and the concern that he would have a court record when he entered high school, we reluctantly conceded.

Four weeks after probation was terminated, Barry was again caught after a new homosexual assault on a nine-year-old boy. This time he was sent to a state hospital for observation.

Due to the particular combination of Barry's pathology and his parents' resistance to treatment, it was necessary to resort to a special strategy. Instead of using the basic therapeutic technique of supporting crumbling ego defenses primarily through the "borrowing of the therapist's ego," we extended this to an interaction between the patient and the law—namely, the court, which could offer him structure, predictability, and specific limits. There appears to be no reason why such interaction cannot take place between the individual and an institution, providing the relationship is a formalized and meaningful one. With patients whose pathology makes them inaccessible for therapy, probation—if precisely planned and implemented—appears to be the approach of choice. It prevents the patient's removal from the community and enables him to pursue his education.

The following case illustrates our approach to the category of adolescents for whom our main goal is placement in a therapeutic environment.

Case 2. John, a 16-year-old, was brought to the court on a PINS petition by his mother because of his uncontrollable behavior and excessive truancy, stealing, and procuring. Two of John's sisters had had psychiatric hospitalizations in the past, and his father had left home suddenly after 21 years of marriage. John had had a long history of maladjustment, and his fa-

ther's leaving had exacerbated his acting out.

Our assessment revealed that although the plan of choice for John would be placement in a residential center, his mother would not accept this because of her close attachment to all her children, especially John. She condoned his behavior as she identified with his acting out and his frequent sexually perverse behavior. Thus the mother gratified her own infantile polymorph-perverse impulses and acted out her own unconscious fantasies. We used two leverages in order to implement our recommendation: 1) we requested the court to keep the case open in order to maintain the crisis momentum; 2) we worked with the attendance officer of the school in order to effect a truancy charge against John, which would make it almost mandatory for the judge to remand the child to a residential treatment center.

The above two cases indicate that although intrapsychic pathology may be responsible for the observable symptoms, the environmental pathology that is an important factor must be taken into account. The implementation of this approach, however, necessitates the development of a truly interdisciplinary orientation. We believe that in such cases the initial intervention (and frequently the only one) has to take place in the sphere of the immediate social environment through the use of community resources and established institutional structures. These cases, which involve a large number of all court-referred adolescents, are the most difficult to handle within the traditional framework because of poor motivation and resistance to treatment. "Treatment," if indicated, can become the responsibility of any team member: teacher, policeman, volunteer, or clergyman. We wish to stress that while we use the term "environmental manipulation" this does not imply an inferior treatment modality but one of choice, based on careful understanding of the patient's dynamics (9).

The third category of cases involves those who are initially unmotivated for treatment and for whom court authority is used differently.

Case 3. David, a 16-year-old, had been brought to the family court on three occasions since he was 11. His first offense was setting fire to a friend; the second, two years later, was assisting in a robbery; and the third was assault while he was intoxicated with alcohol. On each occasion it was recommended that he receive psychiatric treatment. However, the contacts with psychiatric clinics were terminated by his mother shortly after they were initiated. David was the younger of two sons; his father had died when he was six years old. Our assessment revealed that his mother was schizophrenic and that the boy manifested many borderline features as well as a symbiotic relationship with his mother. She perceived any outside contacts with David as threats to their relationship; this caused her to terminate David's prior treatment in the clinic. To prevent the occurrence of this, we made the following recommendation to the court at the end of our assessment procedures.[1]

> In view of the mother's repeated refusal to participate in any treatment program, and in view of David's strong symbiotic tie to her, it would have been extremely difficult at this point to separate the two and to place David. In addition, there are no facilities available for a boy his age except a State Training School or a State Hospital. We would like then to attempt to treat David on an outpatient basis. This will be possible only under a provision that David be placed on a very strict probation in which participation in therapy will be seen as part of probation requirements, and any violation of this requirement will be considered a violation of probation followed by court action.

After the court's acceptance of this recommendation, David was seen regularly in psychotherapy and he never missed an appointment. Initially, he was passively resistant and waited for his mother to pull him out of treatment. The anticipation of disruption made it difficult for him to become involved with the therapist. Although David initially denied this, his resistance diminished when he was assured that his mother could not stop treatment since the matter was in the hands of the court.

The mother, faced with the unequivocal alternatives of having David placed in a state training school or his receiving psychotherapy, chose the latter. To David, the therapist became an ally who on the one hand helped him to stay at home and on the other facilitated emotional separation from his mother, thus making it possible for him to establish a relationship with someone else for the first time. The therapy then became free from environmental interferences.

DISCUSSION

We have attempted to deal in this paper with two major issues in the treatment of adolescents, particularly the delinquent: 1) resistance to treatment and 2) the tendency to act out. Many attempts have been made to explain the adolescent's resistance to psychotherapy and psychoanalysis. Fraiberg (22) considered the aims of puberty and psychoanalysis hostile to each other since the treatment method is perceived as a threat to the defensive structure of the adolescent ego at a time when it is faced with the task of coping with the onslaught of resurgent instinctual drives. To handle this threat the ego brings forth new defenses, which take the form of resistances, refusal to enter treatment, negativism, silence, or abrupt termination. According to Anna Freud (23), the fact that there is little libido available to cathect the therapist results in failure and frustration for both the patient and therapist. Eissler (24), as well as Aichhorn (6), made a distinction between the initial period of treatment, during which the therapist attempts through the use of parameters to engage adolescents in a relationship, and the treatment proper. Aichhorn referred to this initial period as the development of transference.

In our court clinic we have attempted to use court authority as a parameter in dealing with this initial phase. When we believe the youngster can benefit from psychotherapy but this recommendation meets strong resistance from the patient and his family, we generally refer the case back to the court. We then suggest that the youngster be placed on strict probation and that psychotherapy

[1] We always attempt to make our communications to the court precise and to have them supported by available evidence. This appeals to the legal profession and has resulted in excellent cooperation with the courts.

be considered one of its conditions. Failure of the youngster to attend regular sessions in our clinic is considered a violation of probation, with all of its consequences. We feel that this approach deals with a number of important conflict areas. It shifts the adolescent's conflict with his parents and the outside world to one with the clear-cut, definite authority of the court. This new relationship is free of regressive ties, unresolved conflicts, and unfulfilled expectations. It is the law that one has to obey—powerful but anonymous.

Authority, if it is maintained with consistency over a period of time, has a good chance of being accepted by the youngster and may lead to a positive identification with the therapist. As a result we can anticipate a reinforcement of the defensive structure of the ego and the superego, with enhanced ability to cope with the onslaught of instinctual drives.

Psychotherapy by court order creates a new set of interactions and experiences for both the patient and the therapist. The therapeutic situation is seen as a *force majeur*, a societal expectation that has to be faced, explored, and possibly rejected. This obviously must be skillfully utilized by the therapist. The court order thus establishes a new type of rapprochement between the patient and the therapist. Under these circumstances the therapist can avoid being seen as condemning the youngster's behavior, thereby facilitating the identification process and diminishing resistance to the initial stage of treatment. It also preserves the youngster's self-esteem, as he did not ask for help. It is as if he and the therapist were saying: "The court forces us to meet; what do we do now?" The therapeutic interaction takes place then in a "demilitarized zone" of the adolescent's warfare with society and parental authority. The therapist can then align himself, as Aichhorn (6) suggested, with the narcissistic need of adolescence and can try to work with his patient on how to get out of his "mess."

A major theoretical consideration in our approach is our understanding that court authority is perceived by the adolescent as different from the parental one against which he is rebelling. Holmes (12), Szurek (13), and Blos (25) pointed out that the adolescent's proclivity toward action reflects a need to resist the regressive pull of the mother. In introducing court authority we protect the youngster against this pull while at the same time frustrating his attempts to act out. The anxiety created through the removal of the acting out will then by necessity facilitate the psychotherapeutic process.

The very nature of acting out implies a shift from attempts to master to acts of avoidance and to the use of a preverbal kind of problem solving, namely, fantasy and action. This kind of acting out is also associated with impaired reality testing, which is not necessarily psychotic (25). To be effective, a therapeutic intervention must specifically counteract the function of this symptom, which is denial through action. We believe that the function of acting out is blocked by the new situation created by the introduction of court authority and community agency. It brings to an abrupt stop the chain of events that have been perpetuated by the patient's behavior and at the same time intensifies the current crisis, thus making the patient more available for help. The inescapability of court authority is also important in enhancing the patient's ability to test reality.

One must be aware, however, that acting out is psychologically necessary for these patients. Unless one has a foolproof system to contain it, the adolescent will try to find new ways to act out. The extended assessment is thus of major importance because, in addition to providing a dynamic understanding, it offers clues and means for meaningful intervention. It enables us, so to speak, to pull the right strings at the right time. We believe that the combination of authority and psychotherapy (or even the judicious use of authority alone) as "treatment" is particularly justified with adolescents because it can deal effectively with the tendency to act out and is appropriate to the current developmental stage of the patient.

REFERENCES

1. Kessler JW: Psychopathology of Childhood. Englewood Cliffs, NJ, Prentice-Hall, 1966, p 297
2. Hoover JE: Uniform Crime Reports for the United States. Washington, DC, US Government Printing Office, 1970, pp 1–28
3. Dunham HW: The juvenile court: contradictory orientations in processing offenders. Law and Comtemporary Problems 3:508–527, 1958
4. Alexander PW: Of juvenile court justice and judges, in National Probation and Parole Association Yearbook. New York, NPPA, 1947, pp 187–192
5. Nutt AC: The Juvenile Court and Public Welfare Agency in the Child Welfare Program. US Department of Health, Education, and Welfare Publication 327. Washington, DC, US Children's Bureau, 1949
6. Aichhorn A: Wayward Youth. New York, Viking Press, 1935
7. Makarenko A: The Road to Life, an Epic of Education. Translated by Litvinov M, Litvinov I. Moscow, Foreign Languages Publishing House, 1951
8. Rodman H, Grams P: Juvenile delinquency and the family: a review and discussion, in President's Commission on Law Enforcement and Administration of Justice Task Force Report: Juvenile Delinquency and Youth Crime. Washington, DC, US Government Printing Office, 1967, pp 188–221
9. Empey LT, Raban J: The provo experiment in delinquency rehabilitation. Am Sociol Rev 26:679–696, 1961
10. Knight D: The Marshal Program: Assessment of a Short-Term Institutional Program, Part II, Amenability to Confrontative Treatment. Research Report 59. Sacramento, State of California Department of Youth Authority, August 1970
11. Schwitzgebel RK: Developmental and legal regulations of coercive behavior modification techniques with offenders, in Crime and Delinquency Issues: A Monograph Series. Chevy Chase, Md, National Institute of Mental Health, 1971, pp 5–12
12. Holmes DJ: The Adolescent in Psychotherapy. Boston. Little, Brown and Co, 1964, pp 122–170
13. Szurek SA: The role of clinicians in the treatment of juvenile delinquents, in The Antisocial Child: His Family and His Community. Langley Porter Child Psychiatry Series, vol 4. Edited by Szurek SA, Berlin IN. Palo Alto, Calif, Science and Behavior Books, 1969, pp 86–104
14. Shoor M, Speed MH: Seven years of psychiatric consultation in a juvenile probation department. Psychiatr Q 43:147–163, 1959
15. Kaplan M, Ryan JF, Nathan E, et al: The control of acting-out in the psychotherapy of delinquents, in The Antisocial Child: His Family and His Community. Langley Porter Child Psychiatry Series, vol 4. Edited by Szurek SA, Berlin IN. Palo Alto, Calif, Science and Behavior Books, 1969, pp 93–104
16. Goodman JD: New directions in child psychiatry and the juvenile

court. Juvenile Court Judges 21 (1):2–10, Spring 1970
17. Johnson AM: Sanctions for superego lacunae of adolescents, in Searchlights on Delinquency: New Psychoanalytic Studies. Edited by Eissler KR. New York, International Universities Press, 1949, pp 225–245
18. Von Amerongen ST: Permission, promotion and provocation of antisocial behavior, in A Developmental Approach to Problems of Acting Out. Edited by Rexford EN. New York, International Universities Press, 1963, pp 99–111
19. Healy W: Pathological Lying, Accusation and Swindling. Boston, Little, Brown and Co, 1915
20. Erikson EH: Identity and the Life Cycle. New York, International Universities Press, 1959, p 116
21. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964, pp 35–44
22. Fraiberg S: Some considerations in the introduction to therapy in puberty. Psychoanal Study Child 10:264–289, 1955
23. Freud A: Adolescence, in Recent Developments in Psychoanalytic Child Therapy. Edited by Weinreb J. New York, International Universities Press, 1958, pp 1–25
24. Eissler KR: Ego-psychological implications of the psychoanalytic treatment of delinquents. Psychoanal Study Child 5:97–121, 1950
25. Blos P: The concept of acting out in relation to the adolescent process, in A Developmental Approach to Problems of Acting Out. Edited by Rexford EN. New York, International Universities Press, 1963, pp 118–137

References to Questions of the Month

Pages 1070 and 1081:

Question 1: Kolb LC (ed): Noyes' Modern Clinical Psychiatry, 7th ed. Philadelphia, WB Saunders Co, 1968, pp 363, 369

Linn L: Clinical manifestations of psychiatric disorders, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, p 549

Question 2: Goodman LS, Gilman A (eds): The Pharmacological Basis of Therapeutics, 4th ed. New York, Macmillan Co, 1965, p 259

Wikler A: Addictions, I: opioid addiction, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins Co, 1967, p 997

Women Psychiatrists in the United States

BY MARYONDA SCHER, M.D.

The author presents data about the number and percentage of women in medicine, along with their motivations for entering this profession. She also gives recent data about women in psychiatry: their number, areas of specialization, work settings, hours worked a week, etc. After presenting views of the stereotype of the woman physician-psychiatrist and pointing out some of the myths that have been perpetuated, she concludes with the observation that only by working together in the spirit of mutually respectful inquiry can men and women correct the mythologic errors and enlighten one another.

THE POTENTIAL PSYCHIATRIST must be endowed with rich supplies of energy, motivation, perseverance, intellect, and opportunity. He or she must scale a long, arduous, and expensive educational ladder. Nearly a quarter of a century of education—including primary and secondary schooling, college, medical school, internship, and residency—is necessary to earn the title of psychiatrist. Women are endowed with as many of the necessary attributes, including energy, perseverance, and intellect, as men. Yet at every step up the educational ladder, the ratio of women to men decreases. The statistics that bear this out are striking.

Let us examine some of them. In 1967 (1), 2,679,000 young people graduated from high school. That year, as in preceding years, the girls slightly outnumbered the boys (51 percent of the graduating class were girls). That year, 62 percent (1,652,000) of the new high school graduates enrolled in college. Only 43 percent of the enrollees were women. Why the discrepancy? Why should the ratio of women to men drop by eight and a half percent between high school and college? Various authorities (2, 3) estimate that between 75 and 98 percent of the well-qualified students who do not go on to college are women. These are the very students who might be capable of becoming physicians and psychiatrists. Yet these are the ones who are lost from the potential pool of applicants.

What happens to these women that makes them drop by the educational wayside? Two studies offer some answers. The first, a 1960 study of bright children who showed academic underachievement (4), noted that the boys who underachieved differed from the girls in the age of onset. Bright boys who underachieved did so from an early age. In contrast, the girls began to underachieve in high school at about the onset of puberty. These authors concluded that "this contrast is further indication that the achievement drop-off among the girls as they reach maturity is linked to the adult female sex role." The second series of studies (5), carried out in 1969, found that a high percentage of women showed evidence of success avoidance. Young college men did significantly better in competitive tests than their women counterparts. In contrast, the women were able to outperform the men in noncompetitive situations. Many of the women stated that they were actively avoiding success, which they considered to be an unfeminine attribute.

Despite the apprehension of some of them concerning success, women made up 40 percent of the 1967 college graduates. The proportion of women dropped only slightly (three percent) between enrollment and graduation. This suggests that despite negative pressures, women, once started, are almost as likely to finish college as men. But they are not likely to go on to graduate school. Only a small percentage of women apply to graduate programs. Of these, the same proportion are accepted into graduate programs and are provided with support in the form of scholarships and assistantships as men (6, 7). This seems to indicate that women encounter no discrimination in their acceptance into graduate programs. No studies are available, however, on the comparative qualifications such as the grade-point average and aptitude test scores of the men and women accepted.

Revised version of a paper presented at the meeting of the Group Without a Name, Seattle, Wash., September 8–10, 1972.

Dr. Scher is Staff Psychiatrist, Veterans Administration Hospital, 4435 Beacon Ave. South, Seattle, Wash. 98108, and Clinical Associate Professor, Department of Psychiatry, University of Washington, Seattle.

The author wishes to thank Mr. A.H. Kumbar of the APA Division of Manpower Research and Development for supplying data from the 1970 census of psychiatrists.

These data would give a truer picture of possible discriminatory admission practices.

MOTIVATIONS FOR ENTERING MEDICINE

What motivates the few women who do apply to and enter graduate programs? In 1972 Lillian Cartwright published a study of the "Conscious Factors Entering Into Decisions of Women to Study Medicine" (8). She asked 58 women medical students in the 1964 to 1967 entering classes: "Why did you go to medical school?" Their answers indicated multiple and complex reasons, which she was able to categorize under the following headings:

	Percentages
1. Encouragement from others	57
2. Interest (in science, biology, etc.)	48
3. Individuation and self-development	43
4. Mission (altruism, humanitarianism, idealism, etc.)	34
5. Unfavorable evaluation of alternatives	34
6. Response to adversity	22
7. Effects of tradition (parent is physician, scientist, etc.)	21
8. Actualization of parental dream	17

Apparently the encouragement, support, expectations, and hopes (categories 1, 7, 8) of others were important to the majority of women in making their decision to study medicine. At the same time they were exploring their own interests and advancing their self-development.

The comparative attrition rates between men and women in graduate programs are of interest. In medical school women leave their training twice as often as men (16 percent compared with eight percent) (9). Closer scrutiny of these figures reveals that eight percent of the women, compared with three percent of the men, leave school for nonacademic reasons. The remaining women succeed nearly as well as men academically (eight percent versus five percent failures). Whatever the attrition, in 1967 women earned only 35 percent of the master's degrees, 12 percent of the doctoral degrees, and 4.4 percent of the first professional degrees (including M.D., LL.B., D.D., D.V.S., etc.) awarded in the U.S. Women received 574 (seven percent) of the medical degrees that year.

FACTS ABOUT WOMEN PHYSICIANS

I would like next to examine some of the facts about women physicians in the United States. They make up seven percent of all physicians and in 1970 numbered 25,400 (10). Between 84 and 91 percent of these women are professionally active, working either full- or part-time (11). The majority are in pediatrics, psychiatry, general practice, or internal medicine (in descending order). About 70 percent (12, 13) are married, and each family has an average of 2.4 children. The women marry and have their children later than do the men. Nearly all of the women with children have taken leaves from their professional activities during the course of their careers. The percentage of women practicing full-time drops with marriage and with each successive child.

TABLE 1
*Board Certifications Held by Respondents Reporting Any Certification, by Sex**

Type of Certification	Percentage	
	Men	Women
Psychiatry	98	95
Neurology	7	5
Child psychiatry/neurology	6	16
Other	4	1

*Fifty-two percent of those replying to the questionnaire answered this question.

On the average, women physicians practice 2,000 hours a year (that is, 40 hours a week, 50 weeks a year). This contrasts with the 2,831 hours a year of the average man physician. The figures include all professional activities such as practice, research, reading, and attending meetings. Women physicians practice 30 percent fewer hours and see one-third fewer patients than men physicians each year. The women take as much postgraduate training as the men, but they are less likely to be certified in their specialty. Forty-eight percent of the women are self-employed and 31 percent are in full-time salaried positions. This contrasts to 75 percent of the men who are self-employed and 15 percent salaried. People in salaried positions are apt to work fewer hours because of their fixed-hour schedules than those who are self-employed. Since a higher percentage of women are found in these positions, this may account in part for the discrepancy between the hours a year worked by men and women.

FACTS ABOUT WOMEN PSYCHIATRISTS

So much for the data on women physicians in general; now let us examine information about those who go into psychiatry. Between ten and 20 percent (12, 14) of the women graduating from medical school in the United States go into psychiatric training each year. In 1970 there were 745 women residents in psychiatry, or 17.7 percent of the total (15). That same year 187, or 16.7 percent of the total, completed their training and 34 (14.1 percent) terminated their training before completion. The statistics show that women complete their psychiatric training as often as men—indeed, U.S.-trained women complete it more often than men. It is of interest that 40 percent of the women psychiatric residents were foreign-born and foreign-trained, compared to 29 percent of the men residents. On the average it takes longer for the woman resident to complete her training than it does for the man.

There are approximately 3,000 trained women psychiatrists in the U.S., making up 12.5 percent of the total.

TABLE 2
*Area of Practice Reported, by Sex**

Area of Practice	Percentage	
	Men	Women
General psychiatry	49	40
Adult psychiatry	13	16
Child and/or adolescent psychiatry	10	22
Psychoanalysis	10	10
Other (including neurology, geriatric, forensic, industrial, etc.)	18	12

*Ninety-three percent of those who reported that they were working answered this question.

Data from two studies are available about these women. In 1964 investigators from the Langley Porter Institute studied 28 of the women who had taken one or more years of training there and compared them with 28 matched men controls (16). They found that 47 percent of the women and 77 percent of the men were Board-certified, a statistically significant difference. Women were less likely to be married: 77 percent compared with 96 percent. The women spent an average of 31.5 hours per week in psychiatric practice, excluding training, reading, and attending meetings; in comparison, men spent an average of 45.7 hours—again a statistically significant difference. The women who were single or divorced worked an average of 37.7 hours per week; those who were married averaged 29.3 hours. These investigators concluded that the mental health manpower needs of the nation would be better met by appointing men residents to those residency programs which tend to be completely filled. They suggested that programs which had unfilled places could tailor their residencies to meet the needs of women. Of course, if this advice were to be followed by residency programs nationwide, women would be doomed to inferior training since the programs that tend to fill are considered superior to the others.

More recent and comprehensive statistics have been compiled by the American Psychiatric Association from the 1970 census of all known psychiatrists in the United States (17). Questionnaires were mailed to 25,755 psychiatrists, of whom 17,383, or 67.5 percent, responded; 1,983, or 11 percent, were women. The median age for both men and women was between 40 and 44 years.

Ninety percent of both men and women psychiatrists reported three or more completed years of training; 34 percent of the women and 50 percent of the men reported certification in one or more areas. Table 1 gives the type of certification held by those reporting any certification; it should be noted that the percentages for the various certifications cannot be added meaningfully since the number of respondents who hold dual certification is not given.

Forty-nine percent of the men reported their area of practice as general psychiatry in contrast to 40 percent of the women. On the other hand, twice as many women (22 percent) were practicing child and/or adolescent psychiatry as men (ten percent) (see table 2).

A higher percentage of women than of men were working part-time, were retired, or were not working; 81 percent of the men and 73 percent of the women were working (table 3).

The women tended to concentrate their work in fewer locations; the men were more likely to diversify their efforts: 62 percent of the men in contrast to 53 percent of the women worked in two or more locations (table 4).

While women work in fewer locations, they still appear in greater proportions than men in state mental hospitals and in educational institutions other than medical schools. They are employed in salaried positions more often than men (table 5).

Women averaged 39 hours of unduplicated work per week and men 49 hours. A discrepancy in the amount of direct patient contact accounted for most of the difference in hours, i.e., women were in direct contact with patients 25 hours each week in contrast to 32 hours for men. Women spent approximately the same amount of time in consultation, teaching, research, and administration as men (table 6).

Both men and women donated an average of eight hours of work each week (47 percent of those working reported). From the questionnaire there was no way to tell whether the donated hours overlapped or were in addition to the other hours reported.

In any case, the average woman psychiatrist's professional workweek had approximately 80 percent of the number of hours of the average man's; she was more likely to be employed in a salaried position; her time was spent in fewer locations and in more specialized areas (especially those dealing with young people); and although she had an equivalent amount of specialty training she was less likely to hold a specialty certificate. From these data, it would appear that women in psychiatry are far more productive professionally than previous studies have shown. Considering the fact that most of them function in the roles of wife and mother in addition to their professional work, they are not only highly productive people but in addition must be efficient and well-organized.

TABLE 3
*Employment Status of Respondents, by Sex**

Employment Status	Percentage	
	Men	Women
Full-time in psychiatry/neurology	78.6	56.0
Part-time in psychiatry/neurology	2.8	16.9
In residency training	14.4	18.9
In other postgraduate training	0.4	0.6
Working in other field	0.7	0.9
Not working, not retired	0.4	1.7
Retired	2.6	5.0

*Ninety-six percent of those replying to the questionnaire answered this question.

TABLE 4
*Number of Work Locations Reported, by Sex**

Number of Locations	Percentage	
	Men	Women
One	38	47
Two	30	28
Three or more	32	25

*Ninety-seven percent of those who reported that they were working answered this question.

Other data suggest that they are likely to cost their employers less. We have already noted that, although they had equivalent amounts of specialty training, 34 percent of the women and 50 percent of the men were Board certified. Usually salaries are significantly higher for psychiatrists who are Board certified. For example, a differential is paid by the Veterans Administration on the basis of certification. Since fewer women are certified, more are paid at the lower rate even though they may be as well-qualified as the men. By these criteria women psychiatrists seem to be especially valuable in salaried employment, where they are found in proportionately greater numbers than men.

The literature in medicine and psychiatry focuses on the quantitative manpower needs in these fields. In both, there are alleged shortages. Indeed, if the average man must work between 50 and 60 hours a week, a shortage must exist provided he is working efficiently. In order to rectify this shortage, medical and psychiatric educators attempt to ensure maximum productivity from each of their graduates and graduate a maximum percentage of their trainees. But the question might be asked whether the individual practitioner should be expected to solve this problem. Certainly graduates in other fields are not asked to do so. In physics, mathematics, law, education, and engineering, to name a few, an overabundance of graduates for whom there are few jobs exists. Graduates who do not find employment in these fields are a waste too. But the onus does not fall on the graduate; rather it falls on the schools that produce too many graduates and on the labor market, which cannot absorb the overload. The comparative productivity of women has been studied in fields other than medicine; however, only in medicine does the question arise as to whether their lower productivity should ban women from the field.

SOME VIEWS ON WOMEN IN MEDICINE AND PSYCHIATRY

The emphasis on quantity of productive work underplays the qualitative contributions that women make to medicine in general and psychiatry in particular. In 1964, the president of the Women's Medical College of Pennsylvania, Dr. Glenn Leymaster, detailed some of the attributes that women can bring to medicine (18). He said:

> There are many things men can do in medicine which women can do better; i.e., an interest in the concrete in preference to the abstract problems of the community; a certain innate skill in interpersonal relationships; a sensitivity to the feelings of others; great skill in the use of words; a natural attraction to and for infants and children; an unusual tolerance for detail, even repetitious work; fine manual dexterity.

Daniel Blain wrote (2):

> It is time now to speak of the especial need for women in psychiatry, for perhaps by natural inclination and temperament, women are particularly capable with troubled people. Women make excellent physicians, and they make excellent psychiatrists. They are (usually) better endowed than men with the vital trade tools of human warmth, empathy, and capacity for emotional understanding.

Similarly, May Romm wrote (19):

> Women, through their very uniqueness of being females, mothers, or potential mothers, are natural healers who are endowed with a good deal of patience and who are by nature empathic, intuitive creatures, [and] seem suited to the specialty of psychiatry.

And Dr. Blain (2) quoted Dr. Luther Terry, former surgeon general of the U.S. Public Health Service, as saying:

> Women are good for psychiatry. First, I think that from a biological standpoint, the evidence has indicated that they tend to adapt better to many of the sedentary requirements of psychiatry, particularly of psychotherapy, and that in many respects they have less need of some of the action orientation which is often so important to, and on occasion impairs the effectiveness of, men as psychotherapists. Even more important, I think, from a psychological and sociological standpoint . . . women as a group tend to be more intuitive than men and to function better in a nurturing capacity which is often required in psychotherapy.

The composite stereotype of the woman physician-psychiatrist is awesome indeed. She is portrayed as a

TABLE 5
*Location of Practice Reported, by Sex**

Location of Professional Practice	Percentage	
	Men	Women
Private office	67	58
General hospital	23	15
State mental hospital	18	23
Community mental health center and/or government health agency	27	24
Medical school	17	13
Other educational institutions	16	18

*Ninety-seven percent of those who reported that they were working answered this question.

TABLE 6
*Hours Worked per Week by Type of Activity and by Sex**

Activity	Men	Women
Direct patient contact	32	25
Consultation	6	6
Teaching	6	6
Research	8	7
Administration	12	11
Total unduplicated hours	49	39

*Ninety-seven percent of those who reported that they were working answered this question.

quiet, patient, healing, nurturant, practical person endowed with "natural" warmth, empathy, intuition, sensitivity, and understanding—a virtual earth mother. Of course, few of these qualities have been scientifically validated as more characteristic of the female than the male of the species, and men and women psychiatrists have never been compared experimentally as to the relative prevalence of these attributes. Nonetheless, the stereotype of the healing mother-physician seems to exist even among respected members of the profession, and perhaps this is a contribution that women could make to medicine and psychiatry. Perhaps women in greater numbers could alter the image that the American public has of the doctor, i.e., the cold, impersonal, scientific man on a gluttonous quest for riches at the expense of his helpless and suffering patients. It would be nice to modify this stereotype too, but women can make far more basic and important contributions than to suffuse the field with femininity.

NEED FOR MUTUAL ENLIGHTENMENT

Women know what it is to be female; they could share their unique understanding of the female experience with other members of the profession. For centuries women have clung to their secrets of female physiology and psychology while men have plaintively proclaimed and amply demonstrated their ignorance of the subject. Men have harbored their secrets, too, although "anatomy is destiny" and anatomical differences have made it harder for them to do so. Out of such mutual secretiveness and ignorance have grown the great sexual myths of history; e.g., that women have fewer sexual needs and are less sexually responsive than men, that men only want "one thing" of women, that the female's psychodynamics are those of the male castrate. The absurd phallocentric theme has dominated the lore of medicine and psychiatry.

Only by working together in the spirit of mutually respectful inquiry can men and women correct the mythologic errors and enlighten one another. But knowledge is power. No one who anticipates exploitation or contempt from another will reveal his or her power-giving secrets. Yet for centuries men and women have exploited one another—have held each other in disdain. In such an atmosphere, mutual enlightenment was impossible. Respect and trust between equals must prevail if we are ever to know each other. That is why more women must become physicians and psychiatrists, that is why the distribution of the sexes in these fields must become more representative of the population they serve; that is why women must not be token members of the medical and psychiatric professions but responsible and respected students of humanity. Then, men and women working together can correct the false and damaging mythology and contribute accurate data to the body of medical knowledge. Then, and only then, will we serve our patients well.

REFERENCES

1. Women's Bureau: Handbook on Women Workers. Washington, DC, US Department of Labor, 1969
2. Blain D: Women in psychiatry, in Careers in Psychiatry. Edited by Burch C. New York, Macmillan, 1968, pp 111–127
3. Graham PA: Women in academe. Science 169:1284–1290, 1970
4. Shaw MC, McCuen JT: The onset of academic underachievement in bright children. J Educ Psychol 51:103–108, 1960
5. Horner M: Fail: bright women. Psychology Today, Nov 1969, pp 36–38, 62
6. Folger JE, Astin HS, Boyer AE: Human Resources and Higher Education. New York, Russell Sage Foundation, 1970, pp 280–304
7. Statistics: Women and Medical School Application Acceptances. New York, American Medical Women's Association, 1972
8. Cartwright LK: Conscious factors entering into decisions of women to study medicine. Journal of Social Issues 28:201–215, 1972
9. Johnson DG, Hutchins EB: Doctor or dropout? a study of medical student attrition. J Med Educ 41:1099–1274, 1966
10. Pennell MY, Renshaw JE: Distribution of women physicians, 1970. J Am Womens Assoc 27:197–203, 1972
11. Powers L, Parmellee R, Wiessenfeld H: Practice patterns of women and men physicians. J Med Educ 44:481–491, 1969
12. Shapiro CS, Stibler BJ, Zeldovic AA, et al: Careers of women physicians: a survey of women graduates from seven medical schools. J Med Educ 43:1033–1040, 1968
13. Statistics: Concerning United States Women Physicians. New York, American Medical Women's Association, 1972
14. Dykman RA, Stalnaker JM: Survey of women physicians graduating from medical school in 1925–40. J Med Educ 32 (3, part 2): 3–38, 1967
15. American Psychiatric Association, Division of Manpower Research and Development: 1970 Registry of Female Psychiatric Residents. Washington, DC, APA, 1971
16. Weinstein MR: Psychiatric manpower and women in psychiatry. J Nerv Ment Dis 145:364–370, 1967
17. Arnhoff FN, Kumbar AH: The Nation's Psychiatrists—1970 Survey. Washington, DC, APA, 1973
18. Women's new role in medicine. Medical World News 5:78–84, 1964
19. Romm ME: Women and psychiatry. J Am Med Womens Assoc 24:629–636, 1969

Medicine: A Career Conflict for Women

BY MALKAH T. NOTMAN, M.D., AND CAROL C. NADELSON, M.D.

The authors consider some of the issues involved in women's choice of a medical career. The woman medical student has few acceptable role models available to illustrate the variety of possible life and family patterns. In addition, she must cope with the anxiety of medical school and also define her identity as a woman in a "man's world." Women respond to these challenges in a variety of ways related to individual characterological and defensive styles. The authors recommend several approaches to facilitating the participation of more women in medicine.

THE PERCENTAGE OF WOMEN APPLICANTS to medical schools in the United States has changed little in the past 50 years. This is not true in other countries, where women represent a higher percentage of the total physicians. Of American physicians, 6.7 percent are women, a number lower than in any other Western country except Spain (1). Currently the medical profession loses many gifted potential candidates; it further loses the diversity of talents and the assets that women could bring to it.

Despite some impressions to the contrary, women have generally been admitted to medical school in proportion to their applications (2). Thus if ten percent of the applications received by a school are from women, about ten percent of the students accepted are women. With the low national percentage of women physicians remaining relatively constant, it is important to consider the reasons why many qualified women turn away from medicine.

Many reasons have been given for this phenomenon, including the hypothesis that women are less interested than men in pursuing a medical career (3). To some extent this may be true. However, one must consider the pressures that make the choice of and adaptation to a medical career extremely difficult for women. On the basis of our experience with women in high schools, colleges, medical schools, internships and residencies, as well as with those who have careers in the medical field and our most recent work with a group of women students at Harvard Medical School, we will discuss some of the factors involved in the choice of medicine and in the ability to pursue a medical career. We will also recommend several ways of facilitating the participation of more women in medicine.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with Beth Israel Hospital, 330 Brookline Ave., Boston, Mass. 02215, where Dr. Notman is Psychiatrist and Dr. Nadelson is Associate Psychiatrist. They are also with Harvard Medical School, where Dr. Notman is Assistant Clinical Professor of Psychiatry and Dr. Nadelson is Assistant Professor of Psychiatry.

THE CONSEQUENCES OF EARLY PATTERNS

For most people, the development of personality values as well as the crystallizing of life choices begins early in childhood. Girls in our culture are usually encouraged to choose more passive types of activities because these are considered to be more feminine and more consistent with their later roles. Scientific pursuits in particular are frowned upon and considered to be masculine because of their association with assertiveness, precision, and responsibility. In the process of growing up, girls find that they need to deny aggressive traits even when they are actually functioning in areas where these skills are necessary. There are blatant inconsistencies between the passivity and compliance expected of women in relation to men, and the activity and authoritativeness expected in the role of wife and mother.

A girl who is interested in medicine and who comes from a conventionally structured middle-class family faces potential conflict between her identification with her mother and her interests in a different pattern of life. If her relationship with her mother is close and relatively unconflicted, she may have difficulty because she may see herself as betraying her mother and competing with her to achieve more. If a woman has had a troubled relationship with her mother, she may become uncomfortable in seeking a demanding career because this interest may seem connected with the problems in the relationship as opposed to being a true career interest. A girl's identification with her father's professional role may promise an easier pathway for the development of her own serious career interests, but it may interfere with her relationship with her mother and with the resolution of identity issues. Analogous conflicts may be present for a man, but more external supports are available to him to facilitate the resolution of problems of career choice.

It is difficult to distinguish biological from cultural differences between masculine and feminine roles. However, culturally normative values, particularly for gender differentiation in social functioning, are presented *as if* they were biologically based. Expectations are imposed on boys and girls that may differ from their individual personality structures. The idea that medical training is arduous and inappropriate to combine with family life is introduced early. The problem of combining medical practice with a family is seen as a problem for a woman,

TABLE 1
Medical College Admission Test (MCAT) Scores of Women and Men Medical Students Accepted in 1961–1962

MCAT Test	Score		Significance
	Women	Men	
Verbal	554	531	$p<.01$
Quantitative	512	541	$p<.05$
General information	507	523	n.s.
Science	520	539	n.s.

yet we frequently see medical families disrupted by the father's excessive working hours.

Stereotypes may also act in specifically limiting ways for both men and women. The strong, silent type of masculine ideal inhibits the development of sensitivities in men, just as the model of a "proper" woman, helpless and dependent, may inhibit the expression of a woman's activity and independence because she does not want to be considered unfeminine.

Social pressures on a girl who considers a career involving a commitment outside of the home provoke conflicts, particularly when she considers having children. The working mother of young children is often considered an inadequate or "bad" mother; and the woman who chooses not to be a mother is reciprocally viewed as an inadequate woman. Career women whose children develop emotional problems are usually quick to blame themselves for causing the problems. It is interesting that the same criticisms are not made of a woman who spends an equivalent amount of time in volunteer or other charitable activities.

Advisers throughout the years of schooling tend to reinforce the idea that a career in medicine is unsuitable or unrealistic for a woman because of her expected family role as well as because of her "innate" incapacity to meet rigorous demands (as if the demands of raising small children and running a household were not rigorous). The decision for medical school must be made early. Often, by the time a woman has had enough life experience to evaluate the direction in which she would like to go, it is too late to catch up on premedical courses, or she may be told that she is a poor risk because of age, marital status, or children. In other cultures, i.e., western Europe, the same rigorous training is not considered to be too difficult for women.

Applying and gaining admission to medical school seems to be a formidable barrier to many women. A girl asks: "What do I have to be like for them to accept me?" She may look for ways of presenting herself that combine both her own personality and her view of the ideal medical student. She may feel that she must stress those aspects of herself which will gain acceptance. While the same issues confront male applicants, the *idea* of their having a medical career is not questioned.

Admissions committees, in trying to assess applicants, often fall back on the concrete qualities in which men and women seem to differ, such as science grades or aptitude test scores, which have predictive value for performance in the basic sciences in medical school but have no relationship to performance as a physician (4) (see table 1).

A child relies on models of successful people with whom he can identify to help define his role in society. Problems in the development of positive self-image and self-confidence grow out of the reinforcement of the idea that a woman is considered less adequate than a man. Many women enter medicine with these negative feelings about themselves. Those women who have visibly succeeded often represent only a small range of possibilities of life-styles. A girl may see herself as having no choice but to identify with the somewhat vague and scatterbrained conventional feminine style as the only alternative to being termed aggressive and castrating. Such polarization occurs because of the absence of other suitable models for identification for women. (Men are also prone to stereotyping women physicians because of the limited number they encounter.) To cope with the anxiety produced by conflict between the acceptable and desired roles, many women use denial and reaction formation.

In our culture medicine has been viewed as a masculine profession. Expectations in the doctor-patient relationship are connected with this idea. We think of patients as we think of women and children, expecting passivity and compliance from them. Doctors often assume the role of protective father with a dependent child. This model may diminish communication by its rigidity and condescension and thus may prove destructive to the goal of optimal care. Patients contribute to this transference-countertransference phenomenon by viewing the doctor either as a powerful, aggressive figure or as a warm, comforting, supportive one. The patient's early life experiences determine how he or she views the relationship with the doctor. In terms of potential gain to the patient, the possibility of being able to choose a doctor of either sex may be of major importance.

THE WOMAN MEDICAL STUDENT

All students share a variety of stressful experiences when they enter medical school. Since responses to stress are determined by each individual's past developmental encounters and intrapsychic processes, as well as by the challenge of the situation, one would expect to see the use of a variety of types of defense mechanisms to facilitate adaptation. Keniston has described the most frequently found adaptive styles in students as counterphobic, alloplastic, and obsessive-compulsive (5). Students place a special reliance on isolation and intellectualization. The period of medical school coincides with the late adolescent period of identity formation for most students, and the use of "less mature" defenses such as denial may be increased by identification with those physicians who are their teachers. The stresses and responses also change for each student with course material, year in school, and the interpersonal aspects of the student's life.

All students share a common goal—to develop an

identity as a physician. The woman student has an additional task; she must define her identity as a woman in a 'man's world" and cope with the myths about her ability o remain "feminine" and be a doctor. The atmosphere in nedical school is usually highly competitive. A woman :oming from a coeducational school has, for the most part, had the occasion to confront competition with men n her premedical studies. For the student from a woman's college this competitiveness may be a new, frightening, and demoralizing experience.

The conflict between passivity and activity is continually present. Many women students withdraw; they may also hesitate to offer correct answers in order not to appear too competitive. Other women do not seem to feel hampered by these restraints; some deny them, and many others have worked them out previously. Those women who handle the challenge by attempting to be "better men" and to perform as "one of the boys" find themselves able to function well academically, but often, after a few years, they perceive that their social relationships are not as satisfying as they would like them to be. The alternative pseudo-ignorant or flirtatious posture feels false and also contributes to difficulties in handling negative attitudes from other students, faculty, or patients when they do exist and of being an active, decisive participant when this is required.

We have been impressed with the frequent discussion of the hostility that many women students feel is directed at them from peers and instructors; they are reminded that each is taking the place of a man who would be more serious about a career. At the same time, many women do find themselves warmly welcomed.

The woman who attempts to maintain awareness, responsiveness, and objectivity is in a difficult position. She often feels isolated and lonely since she is *not* one of the boys. At times of stress she may receive less support from family or friends than her male classmates do. Most physicians can remember the anxieties aroused by the thought of, and then by the encounter with, the human body—first as a cadaver, then as a patient. All physicians must face life-and-death decisions, and all must learn to cope with the anxiety provoked when the dilemma of how much one must learn in order to avoid *the* potentially fatal mistake is encountered.

The tension of this period and the confrontation with one's human limits include learning to look at suffering, pain, death, and also at sexuality. Anxiety may be denied or displaced in various ways onto other students, instructors, and patients. Women students as a visible minority are not infrequently the targets of displaced anxiety. Men students often seem to have difficulty relating directly to women as colleagues and competitors; instead, they may sexualize their relationships. The women may fall into a pattern of response by reciprocating so that they feel accepted, despite concerns about this mode of interaction. They may feel threatened by it and withdraw from peers and become lonely and at times depressed. Another adaptational pattern is the use of regression. The woman student may find herself becoming dependent on her male laboratory or clinic partner. She may behave in a helpless, childish manner to gain his attention and approval, perhaps in a manner that had successfully accomplished this end in past family experiences.

Another kind of pattern of adaptation derives from the need to appear strong rather than timid. Some women students have a persistent underlying feeling of guilt, as if they have been masquerading as something other than what they are in order to gain admission to medical school. If conflicts lead to ambivalence or hesitation, they are afraid to show it for fear of betraying weakness and of not being "worthy." This is reinforced at times by the attitudes of their doctor-teachers who also handle feelings of helplessness and uncertainty by isolation from their patients and denial of their feelings.

The anxiety and hostility expressed by the jokes at the dissecting table are familiar to anyone who has been a medical student. The few women students are very often the recipients or objects of the jokes. Even though she experiences the same anxiety as the man, the woman student often decides that she must "take it" from her male colleagues so that *women* do not appear weak and inadequate. She learns very early that she is not seen as an individual to be judged on her merit but as a representative of all women who enter medicine.

The nonacademic pressures are great, and perhaps for this reason women do drop out of medical school more frequently than men do (6). Women who leave medical school do so most often in the first year; these students also tend to be the daughters of nonprofessional women (7). The reasons for this may relate both to the identification issues discussed earlier and the conflict about pursuing a career that is not positively valued for a woman, by society as well as by her family. The lack of acknowledgment and support contibutes enormously to the pressure of the experience and the inability to sustain career goals.

Most of the students we have seen have noted that there is a lack of women in prominent faculty and administrative positions to serve as acceptable role models and figures for identification. The need for such figures varies for each student during the course of medical school. Many women medical students, in our experience, seek contact with a group of peers and faculty. Others have individually contacted us at times of stress.

The clinical years often bring a sense of relief despite new issues concerning closeness that arise from direct physical encounters with patients. Many women medical students feel less anxious in the role of caretaker, since it provides a way of combining medical skills with the more traditional expectations of them. It is rare for a patient to be upset because he has a woman student assigned to him. After their initial surprise, many patients even view the situation with relief. This is especially true of those who may look upon a woman as a person with whom they feel less threatened or with whom they can regress or identify, as they feel they can with a mothering figure. Even those men who may initially feel some embarrassment with a woman doctor adapt to this.

As the end of medical school approaches, many women begin to explore how they might define their fu-

ture role as a physician with a family. At this time the married students seem to show increased interest in the life-styles of other women students and faculty. They are seeking additional avenues of identification and other role models. Some women gain acceptance within their student or professional situation only to be regarded as peculiar by the people whom they meet in the world outside of medicine.

During the last two years of medical school all students devote much energy to concerns about specialty and training programs. Women students struggle with their own interests and weigh them against the realities of obtaining internships and residencies and of functioning in specialty roles. Often the field narrows because of the student's desire to feel accepted and needed rather than to continue to fight for recognition, as in a specialty such as surgery where hostility to women is considered great. Flexible training programs are not available in most specialties (psychiatry being a notable exception), even though many women as well as men suggest that part-time programs for some years may be more compatible with their life plans and will not interfere with their responsibilities for patient care.

It is impressive to see how many women do not recognize the pressures under which they operate and the compromises that they have made and continue to make. They feel guilty about making *any* demands on a profession that has been "generous" enough to accept them. Little anger may be expressed at this early phase because the woman represses or denies her perception of her second-class position when applying for internship or residency. Women often accept the "peculiarity" of their position as doctors, and they may share the prejudices of men in regard to their capabilities and the legitimacy of their career aspirations. The essential harmony between "feminine" role expectations and the caretaking activities of medicine is often ignored.

RECOMMENDATIONS

It seems both appropriate and necessary at this juncture to make some specific recommendations for nonacademically related additions to medical school programs:

1. Recruitment programs supported by medical schools to enlighten advisers and students in high schools and colleges about the possibilities of medical careers for women.

2. Women in administrative and faculty positions who are not only visible but available as advisers and friends, to meet with women students in groups or individually, as the need arises.

3. Flexible internship and residency training programs in all fields as well as within medical schools that would be available to *all* students. Limiting such programs to women is discriminatory to men who might also benefit from this kind of practice and would result in a second-class position for the woman physician.

4. Supports for women seeking training programs in areas not traditionally "feminine," such as the surgical specialties. Encouragement to continue and pressure by the medical school on training directors to accept women as house officers are necessary to help support women who risk rejection.

5. Active health programs with gynecologic and family planning services and psychiatric consultation. This not only is important for the health of the woman student but also communicates concern for her needs.

REFERENCES

1. US Department of Labor, Women's Bureau, Wage and Labor Standards Administration: Facts on Prospective and Practicing Women in Medicine. Washington, DC, Government Printing Office, 1968
2. Morgan BC: Admission of women into medical schools in the US: current status. Woman Physician 26:305–309, 1971
3. Bowers JC: Special problems of women medical students. J Med Educ 43:532–537, 1968
4. Gough H: Nonintellectual factors in the selection and evaluation of medical students. Presented at the 77th annual meeting of the Association of American Medical Colleges, San Francisco, October 21, 1966
5. Keniston K: The medical student. Yale J Biol Med 39:346–356, 1967
6. Phelps CE: Women in American medicine. J Med Educ 43:916–924, 1968
7 Lopate C: Women in Medicine. Baltimore, Johns Hopkins University Press, 1968, pp 93–103

DISCUSSION

CORNELIA B. WILBUR, M.D. (Lexington, Ky.)—I would like to see a companion study to the study by Drs. Notman and Nadelson, on "Medicine: a Career Conflict for Men." Like the authors, I also have found that advisers in the school systems state that medicine is an unsuitable or unrealistic career for women. I do not know why some of these advisers (who are women) feel that this is so. Advisers, especially those in junior high schools or those who work with girls between the ages of nine and 14, are most responsible, since it is during these years that most of the women in medicine whom I have interviewed have made the final decision about their career. We have no way of knowing how many girls have been turned away by bad advice, except that of the 10,000 National Merit Scholars interested in going into medicine, one-third are girls.

All medical students look for ways of presenting themselves that will meet the requirements of the medical school and its interviewers. Fortunately, more women are presenting themselves to admission committees as young women wanting to have a career in medicine. Women are beginning to understand that their value in medicine is consonant with their being women and with their femininity. It is true that women medical students currently have too few role models for identification.

The larger part of my experience has been with women students in midwestern schools, and they do not feel that women students tend to withdraw in the class situation. Women students' reactions vary with their personality, but they do not necessarily hesitate to volunteer or respond because of problems of competitiveness. The women students with whom I have dis-

cussed this paper (about 34) do not feel that there is hostility directed at them from their peers; they do, however, feel that there is hostility from some of their instructors. Their most common comment is, "He is afraid of bright women." Women students in this medical school state that they do not feel that they are the targets of displaced anxiety. They recognize that men students frequently flirt with them, but with sex education for medical students there is more open discussion and a more comfortable relationship with male peers in the area of sexuality. Also, perhaps because a woman faculty member heads the sex course, women students do not admit to a need to appear disturbed in this area, and they do not admit to feelings of guilt about being in medical school. These may be differences between women in medical schools on the eastern seaboard and those in the Midwest.

There is clear recognition of the pressures under which women operate in medical school and in internship and residency programs and considerable expression of resentment when these pressures are not shared by their male colleagues. Women are quick to express hostility about problems among themselves and to other women in medical school if they feel the demands on them are greater than they are on their male colleagues. They do not feel that the medical profession has been generous to accept them, but rather that it has been fortunate to get them because they see the value of women as women in medicine. Nurturing capabilities make for easy adaptation in the clinical years.

Enlightened advisers at the junior high school level and beyond are vital. The possibility of flexible internship and residency training programs in all fields for all students is an interesting suggestion. It would seem only sensible for surgical training programs to accept women applicants on an equal basis with men, since women could be valuable in surgical specialties, as well as in general surgery.

Student health programs in undergraduate and medical schools should be sufficient to support women in medical school. Otherwise, these programs would have to be considered to be discriminating. There should be no necessity for special programs other than those which would be normally medically necessary for women at the college and professional school levels.

Having gone through medical school when there was active discrimination against women in medicine, without recourse such as there is today, I wholeheartedly support the recommendations made by Drs. Notman and Nadelson.

Women are not yet being accepted by medical schools on an equal basis with men. Constant, continuous, rigorous effort to achieve such a balance is of the utmost importance to medicine.

Women in Psychiatry: Past and Present Areas of Concern

BY NANCY A. ROESKE, M.D.

The APA Task Force on Women was created to study the special issues and problems of women, especially in relation to the practice of psychiatry, and the special concerns of women psychiatrists. In this paper, the author details the specific areas the task force is examining, summarizes the findings of some of the few reports in the literature, and outlines the projects the task force has undertaken.

AT ITS ANNUAL MEETING in 1972, the American Psychiatric Association appointed a Task Force on Women under the Council on Emerging Issues. The task force was created to examine two major areas: 1) special issues and problems of women in general, as those problems arise in the practice of psychiatry, and 2) special concerns of women psychiatrists. The 12-person task force[1] has had two meetings.

Before setting out in any given direction, the task force members decided to review the reports of previous APA meetings centered on women and to review the literature for articles relevant to its major areas of concern: activities of women psychiatrists, pay scales, working hours, academic and administrative positions, availability of part-time jobs, residencies that have special arrangements for mothers, provisions for reentry into professional life after childbearing, transference and countertransference problems of women psychiatrists, and women residents' professional handling of sexuality with peers and patients. The task force also seeks to encourage women APA members to participate more in their dis-

Read at a panel held at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Roeske is Director of Undergraduate Curriculum and Associate Professor, Department of Psychiatry, Indiana University School of Medicine, 1100 West Michigan St., Indianapolis, Ind. 46202, and Chairperson of the APA Task Force on Women.

[1] A list of the members of the task force appears in appendix 1.

trict branches and APA's working committees.

1966 APA MEETING ON WOMEN IN PSYCHIATRY

The training and functioning of women in psychiatry was the focus of a 1966 meeting in Philadelphia of the Committee on Manpower, chaired by Dr. Daniel Blain (1). The summary of this otherwise unreported meeting, like other reports in the literature, emphasized that some of the statistical information on women in medicine (and thus in psychiatry) has certain implications for women's functioning in this profession. It was noted that only seven percent of all physicians were women; 12 percent of psychiatrists were women. More women than men (approximately 18 percent) worked part time and more women than men worked for unremunerated hours. There were fewer women than men in psychiatry in such positions as consultant, teacher, administrator, and researcher.

While the percentage of women accepted into medical school has fluctuated over the years (though without any discernible trend), the total percentages of men and women accepted have been similar. In 1961–1962, out of all those who applied to medical schools, 63 percent of the women applicants and 60 percent of the men applicants were accepted. Thus the fact that there were fewer women in medical schools reflects the fact that fewer women applied to medical schools.

The participants in the 1966 conference noted that the advantages of psychiatry for women included the relative flexibility of one's schedule, the challenge of the work, the less frequently encountered prejudices toward women, the less physically demanding nature of the work, the possibility of regular hours, and the potential for capitalizing on the feminine characteristics of "mothering, intuitiveness, sensitivity, and gentleness."

The particular problems encountered by women in medicine were found in the area of social acceptance, where pressure against one's career choice by peers, superiors, and family was still prominent. Other social pressures mentioned included the stereotyping by the mass media of the woman as a homemaker and the questioning, rather than the sanctioning, of a woman's right to attend college. Other obvious problems included the lack of flexibility at all levels of training, linked with the higher rate of attrition of women in medical school, the absence of refresher courses for the inactive or temporarily less active woman in practice, the excessively long training period between entrance to college and the end of residency, and the role conflict, both external and internal, of wife versus mother, versus doctor, versus competitive peer, versus submissive woman, versus aggressive partner, versus companionate listener.

THE SELECTION PROCESS FOR PSYCHIATRY

The selection process for psychiatry formally begins with the admissions committee of the medical school. In 1970 Dr. Harold I. Kaplan (2) concluded a seven-year study on more effective recruitment and utilization of the talents of women physicians and on resistance to them. On the basis of an authoritative survey of women physicians by Dykman and Stalnaker (3) Kaplan estimated that 38 percent of the 17,000 women physicians in the United States had to remove themselves from professional activities for an average of four years because of pregnancy and family commitments. Thus the nation was deprived of 25,840 woman-years of medical practice.

Although the percentage of women among medical students in the United States increased from 4.5 percent in 1929 to 8.5 percent in 1961, the United States still lags far behind other countries in these percentages. Many reasons may be given for the disparity between America's utilization of women in medicine and that of the rest of the world. Dr. Kaplan explored the area of prejudice against women physicians on the part of medical educators and he found that there was a significant resistance to admitting women into medical school, whether they were single or married and whether they had children or not. Dr. Kaplan did not comment upon the fact that, in spite of their stated resistance, medical school educators admit the same relative proportions of women and men applicants.

The resistance to making adequate provisions for women once they are in medical school (that is, if they marry, have children, and encounter problems unique to women, such as childbirth and the care of children) is probably more professionally disruptive and distressing. Schools may refuse to provide any time off for childbirth, or they may insist upon rigid adherence to work or night schedules when minor modifications in these areas might allow a student who is a mother to successfully perform both functions. In fact, many medical schools have observed that women students usually return to school a few days after giving birth. This observation is used as a justification for the conclusion that, if they are motivated, women are capable of adhering to rigid educational programs, and the observation is used to confirm the absence of a need for special programs for physician-mothers. Dr. Kaplan's aforementioned advocacy of greater flexibility in medical education represents a criticism of the American model. Dr. Kaplan has stated that the enforcement of such a rigid system appears to seriously limit the recruitment of women into medicine. Using the example of foreign countries in which flexible provisions are made for women, Kaplan concluded that such flexibility is a major factor in encouraging more women to seek medicine as a career.

WOMEN IN MEDICINE

What kinds of women become physicians? A 1971 study by Dr. Phoebe Williams of 212 Radcliffe alumnae who had become physicians (4) supported earlier studies reported by Lopate in her classic book, *Women in Medicine* (5). The background of women physicians may be characterized as urban and affluent, their parents as

highly educated, and their fathers as professional men or businessmen. Dr. Williams reported that one-fifth of the fathers who were professional men were doctors. Among the most important factors named in choosing medicine as a career were an interest in the biological sciences, a desire to help people, and a wish to do something worthwhile in which the woman could function in an independent manner. This last theme appeared in several forms: wanting to have a career with challenge, needing stimulation, desiring work that would permit a high degree of individualism and continually test one's mettle, and, in general, finding enjoyment in that which does not come easily. Another strong motif in choosing medicine was the importance of a relationship with an adult who had been encouraging. This person may have been a relative, a doctor, a school science teacher, or a college professor. No matter who it was, it was always someone who provided hope and support in place of discouragement.

What kinds of concerns do women in medicine express? Dr. Williams found that the younger women, those who had graduated since 1950, expressed more concern regarding the problems of combining career and marriage and career and children than did women who had graduated between 1910 and 1950. Dr. Alice Rossi (6), in her 1965 study of the career choices of women college graduates, had found that women frequently do not go into medicine because it is perceived as too demanding a profession to combine with marriage and family responsibilities.

That a medical career is highly demanding cannot be denied. In addition to a long and arduous training period that produces strain and demands time, energy, and emotional reserves, the profession of medicine entails at least two areas of expectation that can have especially stressful consequences for married women. The first of these is that medicine assumes the character of a calling. Unusual dedication is expected both by the physician and by the public. The second is that physicians bear responsibility for peoples' lives, and the requisite knowledge and skills become obsolescent very rapidly. Since the stakes are very high, women doctors, like their male colleagues, set stringent standards for themselves, and they need continual involvement in the world of medicine.

Thus the critical areas mentioned by the women in the Radcliffe study were the conflicts involving such problems as the birth of children, obtaining adequate household help, caring for children, and stresses in the relationship with one's husband. These family-career conflicts and their resolution led half the women to reduce their career demands by working fewer hours, changing to a less time-consuming specialty, or giving up medicine temporarily.

Pennell and Renshaw (7) listed the distribution of women physicians in the various specialties in 1970. The majority of women physicians enter the four specialties of pediatrics, psychiatry, general practice, and internal medicine. Of the 2,942 women psychiatrists who reported, 43 percent worked full time in private practice, 25 percent were engaged in full-time hospital staff practice, 5.5 percent were engaged in the administration of psychiatry, and three percent were engaged in either teaching or research. Women in psychiatry constituted 12.7 percent of the 23,236 practicing psychiatrists.

PROJECTS OF THE TASK FORCE ON WOMEN

The Task Force on Women concluded, at the end of its first meeting in November 1972, that it had two major goals: 1) to function as a consciousness-raising group for both men and women in psychiatry and 2) to collect data on men and women psychiatrists that would delineate pertinent problem and conflict areas and to offer suggestions and recommendations for solving the problems. To these ends, the task force has initiated a number of projects that have had both immediate and potentially long-range effects.

1. The task force has written to all psychiatric journals to ask whether women serve on their editorial boards and what their policies are on the acceptance of articles about and by women. It has also been recommended to all journals that manuscripts be sent to reviewers without any identification of the author to see whether this practice will eliminate any covert or overt prejudice against either the sex or the relative status of the author.
2. The National Institute of Mental Health and the American Medical Association have been questioned about the extent of their utilization of women psychiatrists.
3. A talent bank of women in psychiatry has been established at APA headquarters. An article in *Psychiatric News* urged women to submit their curricula vitae to the talent bank, specifying their availability for a position (including any geographical preference) and their particular areas of interest and expertise. Institutions seeking to hire psychiatrists are urged to avail themselves of this list of women.
4. A member of the task force attended the Conference for Residency Training Directors and suggested that a course on the psychology of women be offered during residency training. The task force plans to review the curricula of currently offered courses and to make this material available to all interested training directors.
5. A monograph summarizing the literature about women in psychiatry and the psychology of women is being planned.
6. Questionnaires designed to explore the role of women psychiatrists in education are being prepared for departmental chairmen and training directors.

Both the literature regarding women in medicine and the transcript of the 1966 conference clearly indicated the need for women to be on the admissions committees of medical schools, for women to be active in counseling women who are considering dropping out of medical school, and for women to take an active role in revising medical school training programs so that they are more congruent with a woman's role as a mother. The chairmen of departments of psychiatry can play a vital role in exerting pressure to include women physicians, not necessarily women psychiatrists, in admissions committees of

medical schools. Furthermore, all women applying for psychiatric residency training should be interviewed by a woman as well as by a man and all known areas of present or potential conflict in marriage, family, and career should be reviewed with the applicants in the context of the demands of the residency training program.

PILOT STUDY OF THE TASK FORCE ON WOMEN

There is a paucity of literature regarding the characteristics of men and women in psychiatry. The task force therefore initiated a pilot study to obtain sociological data, information on motivational factors and concerns experienced before entering medicine and psychiatry, and data concerning sources of emotional support, principal employment, professional activities, marital and family status, and family-career conflicts and their resolution.

The sample was composed of 35 women and 35 men who are APA members. They ranged in age from 27 to 62 years. About 75 percent of both men and women were either the firstborn or only children. Parents and spouse were named as the major sources of emotional support for both men and women. The decision to enter medicine tended to be made earlier by the women than by the men. The fact that more women than men decided to enter medicine before high school or during high school implies strong family support for this career choice, but research is needed to test this hypothesis. In contrast, the women decided later than the men to go into psychiatry. This is congruent with the statistics cited by Dr. Leo Madow (1, p. 20) at the 1966 meeting, which showed that there were greater proportions of older women than older men in psychiatric residency training. This finding has implications for training and professional functioning and demands greater scrutiny.

Data obtained on the source of financial support for medical school and residency training did not reflect the findings of other studies, which have indicated that women in medicine do not accept scholarships because of the prospect of a negative dowry. Sixty percent of both men and women psychiatrists reported that their parents supported them through medical school. The chief source of support during residency training was from the training stipend. The major area of concern was not the problem of financing training, as reported in other studies, but rather the long-term commitment required.

In general, the men reported a lower level of concern about entering both medicine and psychiatry. On the other hand, the women had two major areas of concern: combining profession and marriage, and combining profession and children. This concern was expressed by almost fifty percent of the women respondents.

In regard to the factors that influenced their career choice, both men and women listed an interest in biological sciences, a desire to help people, and an interest in psychology. But women checked these items three times more frequently than men. Finally, 17 of the women, but only one man, acknowledged that having experienced an illness oneself was a motivating factor.

Only two of the 35 men and four of the 35 women were single; three men and four women were separated or divorced. Two-thirds of the respondents were married by the time they entered residency training. Three of the men and 13 of the women were married to physicians. Although both men and women psychiatrists became parents during college, medical school, and residency training, most of the men psychiatrists' children were born before or during their residency training. Twenty-two of the women psychiatrists' 44 children were born after the women had completed their residency training, while only nine of the men psychiatrists' 32 children were born after the men had completed their residency training. The women have handled the family-career conflict by reducing their career demands, working fewer hours, changing to less strenuous and less time-consuming areas of practice, or giving up the care of their children to a housekeeper or parent. A few gave up the practice of psychiatry temporarily.

This pilot study indicates few significant differences between men and women who enter psychiatry. The major focus of difference appears to center on the family-career conflict. Some of the women in this study appear to have resolved this by having fewer children during their training and/or by delaying family formation until they had completed their training. Thus two-thirds of the children born to these women physicians must have been born after the women were 30 years old, which would increase the risks for mother and child. These data support other studies which recommended that women should have the option of flexibility in professional training programs and that child-care facilities should be available. The validity of this assumption needs to be further tested in future questionnaires, since it is not known whether women psychiatrists would want such a program. There also needs to be further clarification of why women wait until late in medical school or until they are in another residency training program before entering psychiatry. Finally, the fact that two-thirds of the women were married to men who were not in the medical profession suggests that they are likely to face marital problems based on their husbands' lack of understanding of their dedication to their profession.

In conclusion, the Task Force on Women believes that we should begin now to consider changes in our training programs and vocational opportunities on the basis of our current knowledge of the conflicts that face women entering residency and practicing psychiatry. The number of women entering medical school is increasing. Approximately 13 percent of those entering medical school in the fall of 1972 were women. Psychiatry has had and should have a special appeal to women and a need to use the talents of women.

REFERENCES

1. Barton G: Summary of the 1966 Symposium on Women in Psychiatry. Washington, DC, American Psychiatric Association Library, 1973 (unpublished transcript)
2. Kaplan HI: Women physicians: the more effective recruitment and

utilization of their talents and the resistance to it: the final conclusions of a seven-year study. Woman Physician (J Am Med Womens Assoc) 25:561–570, 1970
3. Dykman RA, Stalnaker JM: Survey of women physicians graduating from medical school in 1925–1940. J Med Educ 32(3, part 2):3–38, 1957
4. Williams PA: Women in medicine: some themes and variations. J Med Educ 46:584–591, 1971
5. Lopate C: Women in Medicine. Baltimore, Johns Hopkins University Press, 1968
6. Rossi AS: Why so few women become engineers, doctors, and scientists; in Women and the Scientific Professions. Edited by Mattfeld JA, Van Aken CG. Cambridge, Massachusetts Institute of Technology Press, 1965, pp 51–127
7. Pennell MY, Renshaw JE: Distribution of women physicians: 1970. J Am Med Womens Assoc 27:197–203, 1972

APPENDIX 1

Members of the APA Task Force on Women

Chairperson: Nancy A. Roeske, M.D., Indianapolis, Ind.

Mary Ann Bartusis, M.D., Morrisville, Pa.

Elissa P. Benedek, M.D., Ypsilanti, Mich.

Nancy Durant, M.D., Plainfield, N.J.

Leon Eisenberg, M.D., Boston, Mass.

Richard Green, M.D., Los Angeles, Calif.

Martha Kirkpatrick, M.D., Los Angeles, Calif.

Carol C. Nadelson, M.D., Boston, Mass.

Anne M. Seiden, M.D., Chicago, Ill.

Carroll Smith-Rosenberg, M.D., Philadelphia, Pa.

Carol S. Wolman, M.D. Philadelphia, Pa.

Consultant to the Task Force on Women: Renee C. Fox, Ph.D., Philadelphia, Pa.

Liaison member from the Council on Emerging Issues: Perry Ottenberg, M.D., Philadelphia, Pa.

Training the Woman Resident To Be a Psychiatrist

BY ELISSA P. BENEDEK, M.D.

The author focuses on the problems of the woman resident and draws upon her own experience to illustrate her point that women are not accorded the same consideration as other minorities and that, for women, the residency period may be one of loneliness and misunderstanding. She observes that women have as much to learn from men as men from women and concludes that, if there are enough women staff members to make it possible, each woman and man in a residency program should have some personal supervisory experience with a woman staff supervisor.

PSYCHIATRIC RESIDENCY TRAINING is a long, arduous, and sometimes lonely postgraduate medical experience. Because of the specialized and unique nature of the training, psychiatric educators in charge of such programs have focused on the social and emotional problems that are involved in converting the novice first-year resident into a skilled psychiatrist. Such relevant issues as identity problems, the doctor-patient relationship, coping mechanisms, and learning problems have all been intensively and extensively discussed and reviewed (1, 2). Conspicuous by its absence, however, is a body of literature on the special problems of residency training for minority groups: residents from lower socioeconomic classes, foreign residents, and women.

After looking at the few articles already in the literature, this paper will focus on the special problems facing the woman resident as she enters psychiatric residency training. My intent is to share some of the unique experiences, thoughts, feelings, and recollections of a woman resident; to explore the common problems that women residents face; and to make recommendations on areas that psychiatric educators need to reexplore in order to better recognize and understand the unusual position of the woman resident. Such a reevaluation of traditional

Dr. Benedek is Associate Director for Training and Education, York Woods Center, Ypsilanti State Hospital, 3501 Willis Rd., Ypsilanti, Mich. 48197.

The author wishes to thank Mr. Norman Johnston and Dr. Christine Bieniek for their assistance in the preparation of this paper.

programs also offers the potential enrichment of the training experience of men residents by expanding their understanding of the psychology of women.

The problems faced by the woman medical student have been effectively and sympathetically described by Notman and Nadelson (3, 4). These young women explored a woman's admission to medical school, her student years, her development both as a woman and as a woman physician, and the academic and nonacademic pressures that women face. They ended their comments by discussing the tentative development of a woman student's specialty choice. They concluded that the choice of a specialty requires a compromise between the student's professional interests, her personal plans, and the available training programs. Kaplan, too, noted that personal plans are of importance in admission to medical school (5). In his 1970 report of a survey of the attitudes of American medical schools toward women medical students, he concluded that medical schools are simply resistant to admitting women, whether they are single or married, with or without children. They fail to make adequate provisions for women in school (e.g., if they marry and have children) and offer no help if students encounter problems unique to women (e.g., childbirth and care of children). Although these studies deal with women in medical school, many of the problems and experiences faced by the resident psychiatrist are the same as those faced by medical students.

THE FIRST HURDLE: ADMISSION

No one has openly admitted that there is a quota governing the number of women applicants who are accepted to a general psychiatry residency training program. If a quota exists, it is probably in the minds of training program administrators and is certainly not spelled out in program descriptions and brochures. Women applicants who are interviewed for a first-year residency position are forced, however, to wonder about quota systems. The applicants have already had recent experience with a quota system when they were admitted to medical school. Procedures for admission to residency programs vary, but most have in common a personal interview with a senior staff member and a fellow resident. As a woman applying for residency training, I wondered why all of my interviewers were men. Even though there were reputed to be women psychiatrists and residents on the staff, none of them was involved in the selection process for the training programs I considered.

For me, admission to residency was a *déjà vu* phenomenon. Notman and Nadelson (3) suggested that many women who apply to medical school ask themselves, "What do I have to be like for them to accept me?" As an applicant I felt I had to screen my answers carefully or I would find myself denied the right to a career in psychiatry. Selection interviews are, of course, conducted with different focuses by different clinicians. But during the course of all my interviews I was struck by the discomfort of my examiners as they questioned me about my career plans. Though their psychiatric training seemed evident as they attempted to be nonjudgmental, it was obvious that some of them enthusiastically approved and others disapproved of my responses when they asked me why I wanted to be a psychiatrist, what kind of psychiatrist I wanted to be, and where I intended to practice.

Their uneasiness was even more apparent as they tried to frame legitimate questions about the compatibility of a successful career in psychiatry and a successful marriage and family life. At the time I applied for my residency I had been married for three years to a young man who had an established professional career. My interviewers stumbled as they asked legitimate questions about my husband's career plans and especially about the possibility of future moves. A survey of my colleagues revealed that relatively few men were questioned about family plans but almost all women were.

The first hurdle on the road to training, then, is gaining admission to a high-caliber residency program. This requires expert skills on the part of the woman candidate in recognizing and dealing with the anxieties, challenges, and threats she presents to the men training directors simply because she is a woman. Of course, there are some training programs specifically tailored to women. One such program exists at the Department of Psychiatry of New York Medical College; it was instituted in 1962 as a special residency training program in psychiatry for physician mothers (6). The program allows women physicians with children to proceed in training by modifying the traditional routine of a psychiatric residency. While meeting the American Board requirements for psychiatry and neurology, women physicians are offered flexibility in scheduling and are given summer, Christmas, and Easter off to be with their families. But this is a specially designed program for mothers and, as such, seems to have all the advantages and disadvantages of a Seven Sisters women's college. A woman's perspective on issues is overemphasized, while the male viewpoint is missing. Women psychiatrists have as much to learn from their male colleagues as their colleagues have to learn from them, especially in the areas of child development and general psychology.

THE VICISSITUDES OF TRAINING

After admission to the average residency training program, the woman quickly finds that, although the programs have geared themselves to individualized training for some other minority groups, no special efforts have been made to recognize and deal with the problems of the woman resident. In a field that deals with the person as an individual, it is sad to see that few attempts are made to individualize training. Administratively, the new woman resident is not seen as an individual, or as different in any way from men residents, and no special provisions are made for combining career training with her nonprofessional life.

Residency training programs boast of the compatibility of general psychiatric training with psycho-

analytic treatment and work on advanced degrees at universities. It is possible to make special arrangements to pursue joint programs in psychiatry and public health. But the realistic problems for the woman resident, such as "on call" time, rooming arrangements, vacations, and holidays, are nonnegotiable issues. They are simply ignored. No special arrangements are suggested for the woman resident and she quickly recognizes resistance and a thinly disguised hostility if she calls attention to her "different" but parallel career development needs as a wife and mother. In the last year of my residency, during a planned pregnancy, I was shocked to find that my situation was viewed as unique, even though a colleague had been pregnant the previous academic year. The training institution had no administrative plans for a pregnant resident. My supervisors never commented on my pregnancy, the special needs I might have had because of my pregnancy, or how pregnancy would affect the staff and patients I dealt with.

In a typical program, a resident undergoing transition from the medical model to the psychiatric model finds support in peer groups and supervisors. The woman resident in the average training program frequently does not have peer groups; she left them behind in medical school. As a lone woman, she cannot share her anxieties and concerns since there is no one with whom to consensually validate her fears and insecurities. It takes a special effort to learn that many of her newly discovered conflicts come from the problems of being a psychiatrist and not from personal difficulties. Denial is a common defense that all residents use to avoid the anxieties of the first year, but the use of denial frequently disappears in the camaraderie of the peer group. The woman resident, because of her isolation and lack of peers, confuses the men residents' denial of anxiety with reality. An easy cop-out for men colleagues to use when denying anxieties is, "Oh, you are just being a silly girl." It is only after her residency training that she learns that the horrors of the first year are common and not unique to her, and that she is not the only one feeling anxious, uncomfortable, and totally inadequate.

Similarly, sexual feelings between men and women colleagues sometimes arise because of the closeness that is necessary in the peer group and because new residents are beginning to explore themselves more closely. The introspective woman, having been through the medical school experience in an almost all-men atmosphere, is better prepared to recognize and deal with some of these feelings than her men colleagues because of their limited association with women professionals. However, honest, open communication about these feelings, as well as other feelings between men and women that arise simply from sexual differences, is not common.

If women supervisors are available, they currently provide neither a peer group nor role models. Many of them have been trained in the era in which the psychology of women dealt exclusively with phases of the menstrual cycle and its psychological consequences (7). They have long been enmeshed in academic and professional struggles with their men colleagues and may frequently have been defeated or left on the lower end of the institutional structures. For example, the academic department of psychiatry where I had my training had women on its staff. Regardless of their professional expertise and qualifications, however, there was not a single woman above the level of instructor. In their decisions not to "buck the system," many of these women have disguised the very characteristics identified by society as being feminine that are most helpful in caring for people. Their empathy, kindness, and intuitiveness were defended against as they identified with male medical models and the supposed masculine values of aggressiveness, impersonality, and distance. I found no special sensitivity in any of my women supervisors to the problems of women residents and problems of women patients. They were, however, expertly skilled in "getting along with the establishment."

A woman resident certainly needs specialized supervision. The very fact that the resident is a woman brings issues to the forefront in all of her relationships with patients. There are common transference reactions that must be recognized and identified both by the patient and the therapist that occur simply because of her sex. Femininity is a constant reminder of past female figures. Typically, and in my own experience, the woman receives many requests for factual information about her previous training, her experience, and her own family. These requests hide different fantasies for different patients and must be explored on an individual basis. In my own experience, it was critical for many patients to verbalize their concerns about having a woman as a doctor before they could begin to place any therapeutic trust in me and start a relationship. Early in my residency training, a psychotic male patient propositioned me; his intent was not sexual but rather to form a relationship. Only years later was I able to recognize the true meaning of his crude advances. At the critical moment, when supervision would have made the difference, my supervisor stressed the importance of confronting this desperately ill patient with the reality of "I am your doctor, not your whore," rather than wondering with me what the patient was trying to tell me.

After a relationship is formed, other common themes must be recognized and explored. These include the questions of whether I have abandoned my family, whether I will abandon the patient, and what a "nice girl" like me is doing in such a crazy place as a hospital. Separation and termination are frequently colored by early fears of maternal abandonment. Of course, special events in the life of the woman therapist that cannot be and should not be avoided are common knowledge to patients. Such factors as marriage and pregnancy must be dealt with; the therapist needs both the supervision and the didactic material that can be given by sensitive and knowledgeable supervisors.

Previously, when I was discussing the lack of administrative accommodation for a woman, I cited my own experience during pregnancy. During the same pregnancy I was very sensitive to the fact that none of my supervisors discussed with me the effect that my pregnancy might

have on the child patients I was treating. Granted that none of these supervisors had been through pregnancy themselves, there was some literature that could have helped me understand the changes I was undergoing and their effect on my patients. No one made me aware of this literature and no one suggested that I use my experiences to add to it.

Residency training typically ignores the whole area of female psychology as it differs from male psychology. For example, there are special issues that are presented by women patients. We are only now beginning to recognize that the bored housewife syndrome is not necessarily psychopathology but a healthy response to a career as a chauffeur, maid, and jack-of-all-trades. Instead of pinning labels on women it may be appropriate to examine the reality of women patients' depression, boredom, anxiety, lack of fulfillment in life, and loss of identity. The plight of the woman patient is not adequately discussed in the psychiatric literature, and those in the best position to contribute to the literature on this subject are not encouraged to do so. The role of society in fostering psychopathology has long been recognized, yet all of the special problems that have been categorized in the past as affecting primarily men or women have not yet benefited from new psychiatric insights about the role of sexual stereotyping in mental illness.

The woman resident who has looked for and found no help from supervisors and peers will find none in seminars. The essence of the Freudian view of women, which permeates most seminars, is captured and caricatured beautifully by Natalie Shainess: "Women are passive, masochistic, more prone to jealousy, have weaker superegos than men and a weaker sense of justice. One of their major problems is penis envy, its hallmark being feminine aggression" (8). The alternate, more appropriate view of women that is proposed by Shainess—"Female psychology is the area which deals with the psychic components of gender and of the reproductive experience" (8)—is never taken into consideration. Child development, psychopathology, and psychotherapy are traditionally oriented and very few of the ideological concepts championed by the new femininist movement have sneaked into reading lists and seminar rooms. There are no seminars or tutorials on the developmental psychology of women. Contributions by Shainess, Bardwick (9), Miller (10), and Horner (11) and the whole proliferating literature on the development of women have not marked traditional residency training. It was only late in my career, after doing some original research, that a man supervisor recommended that I read Nelson's "Anlage of Productiveness in Boys' Womb Envy" (12). The study of the psychology of men and women—their similarities and differences—is critical, important, and enriching for all residents.

During residency training, besides learning to deal with individual patients, the resident must learn to work in a therapeutic milieu. There are many other problems that have to be recognized, confronted, and worked out if the therapist is to be successful. For a woman, the problems are compounded. The woman as a ward administrator is enmeshed in a host of old rivalries. The typical doctor-nurse, man-woman, father-daughter mold is broken. The sensitive woman doctor has recognized and dealt with these issues before, but new nuances come to play in a psychiatric setting. That is not to say that a man therapist does not have to recognize some of these issues ("We nurses deal with the patient 24 hours a day; who are you to tell us what to do when you only see them one hour in therapy?"), but ground has been covered for them by previous men residents and they need not always be pioneers.

CONCLUSIONS

In this era of reexploring and reevaluating traditional institutions, residency training should be scrutinized to see whether in fact it teaches all of the trainees the things that they need to know in order to practice psychiatry after graduation using their own special skills. Such reevaluation should especially look at the role of women in a psychiatric residency. I suggest that training directors reevaluate both the administrative makeup of training programs and the program content. It is certainly possible and advisable to provide enough flexibility in the traditional coeducational residency training program that all residents can pursue their personal and career goals. At the very least, modified schedules can be provided for women who are pregnant, giving them adequate antepartum and postpartum time off, at no cost to their careers. But even more desirable would be a form of parental leave that would be available as a choice to both men and women residents. It is critical that seminars and patient material be reevaluated and reworked to provide additional dimensions of consciousness to residency training programs. If there are available women staff members, each woman and man resident should have a personal supervisory experience with a woman staff supervisor.

As more and more women enter medicine, we can predict that the percentage of women who enter psychiatry will increase and the percentage of women available to treat and teach will similarly increase. Professional educators are obligated to improve the quality of the educational experience these young women will encounter and to make it as meaningful, relevant, and enriching an experience for them as for their men counterparts.

REFERENCES

1. Tischler GL: The transition into residency. Am J Psychiatry 128:1103–1107, 1972
2. Ford ESC: Being and becoming a psychotherapist: the search for identity. Am J Psychother 17:472–482, 1963
3. Notman M, Nadelson C: Medicine: a career conflict for women. Am J Psychiatry 130:1123–1127, 1973
4. Nadelson C, Notman M: The woman physician. J Med Educ 47:176–183, 1972
5. Kaplan HI: Woman physicians: the more effective recruitment and

utilization of their talents and the resistance to it—the final conclusions of a seven-year study. Woman Physician (J Am Med Womens Assoc) 25:561–570, 1970
6. Kaplan HI, Kaplan HS, Freedman AM: Psychiatric residency training program for physician mothers: a progress report. Journal of the American Medical Women's Association 19:285–289, 1964
7. Glass GS, Heninger GR, Lansky M, et al: Psychiatric emergency related to the menstrual cycle. Am J Psychiatry 128:705–711, 1971
8. Shainess N: Let's bury old fictions. Psychiatric Opinion 9:6–11, 1972
9. Bardwick J: Psychology of Women. New York, Harper & Row, 1971, p 242
10. Miller JB: Psychological consequences of sexual inequality. Am J Orthopsychiatry 41:767–775, 1971
11. Horner MS: Toward an understanding of achievement-related conflicts in women. Journal of Social Issues 28:157–175, 1972
12. Nelson JB: Anlage of productiveness in boys' womb envy. Journal of Child Psychiatry 6:213–225, 1967

Women in Psychiatry

ALTHOUGH THERE HAS RECENTLY BEEN AN IMPETUS for women to engage in business and professional careers, obstacles to their full participation continue. These obstacles are in part related to traditional attitudes toward women that require reexamination. The difficulties that confront women who seek a career in psychiatry are the subject of a special section in this issue of the *Journal*.

Like all women who desire to develop their skills, women in psychiatry are troubled by the barriers that limit their performance and achievement. That there are obstacles to women's participation is indicated by the paucity of women engaged in the practice of psychiatry and the very small number who are prominent either in academic or policy-making circles. The limited number of women who are professionally effective can be accounted for, in part, by the reluctance of men to accept women as peers and by the hesitation of many women to assert themselves. Both these attitudes have been fostered by the lingering belief that women are or should be passive and therefore are unsuited for occupations that require energy and initiative.

The assumption that by nature woman is passive, which often serves as a rationalization both for men who fear the independence or competition of women and for women who doubt their ability, is based on limited observation and inaccurate interpretations of women's roles. Careful examination of women's behavior and psychology indicates that much of what has been considered passive is better understood as active and receptive. Homemaking is an active task that requires a woman to exercise intelligence and to be receptive to the needs of those for whom she cares. In the past, women have tended to accept passively—although not always without frustration—the role of homemaker as their sole occupation. Changes in patterns and conditions of homemaking have made time and energy available for women who wish to use their talents and skills outside the home.

To deal with the issue of how best to utilize the available talents of women, it is necessary to scrutinize their experiences and accomplishments as they enter various fields in increasing numbers. At the same time, it is essential to refine our ideas about gender-linked attitudes in order to provide an atmosphere in which women can be most productive. Our concepts of activity, passivity, and receptivity require clarification. Do these attitudes differ fundamentally in women and men, or is it rather that they have been expressed differently because anatomical and physical differences have been interpreted in such a manner as to lead to markedly different role assignments? The association between activity and aggression and the stress on the hostile nature of aggression to the neglect of its adaptive aspects have confused the issue. In the course of their work with both men and women, psychiatrists can gather information that is essential if we are to truly understand the psychology of both women and men.

The capacity to bear children poses a problem for women who wish to pursue a career but who do not want to forego the experience of motherhood. We are in the process of examining our patterns of child care and of education and training for women in this situation with a view toward developing programs that will most effectively allow

In this section, the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

women to make their contribution to society and at the same time provide the necessary care for their families.

Women in all fields have assumed leadership in delineating the inequities that have burdened them, in calling attention to the underutilization of their skills, and in offering proposals to correct discrimination against them. Their efforts have been recognized and there has been a positive response in society at large as well as in the psychiatric profession. Interest within the profession is exemplified by the establishment in 1972 of the APA Task Force on Women, chaired by a woman, and by the publication in this issue of the *Journal* of several papers by women on the subject. These events and the large and enthusiastic attendance by both men and women at the May 1973 APA meeting of the Task Force on Women is an encouraging beginning. We look forward to the increased participation of women in the affairs of our Association and to contributions from both women and men that will help to resolve some of the issues pertaining to the roles of both men and women in our profession and in society at large.

REBECCA Z. SOLOMON, M.D.

Dr. Solomon, a member of the Editorial Board of The American Journal of Psychiatry, *is in private practice in Hartford, Conn., is Senior Clinical Associate in the Department of Psychiatry at Yale University, and also teaches at the Institute of Living, Hartford.*

Benjamin Rush: Morality in Government

> It is absolutely necessary that our government . . . should possess . . . the moral faculty, and the conscience of an individual. Nothing can be politically right, that is morally wrong. . . . Virtue is the living principle of a republic.

SO WROTE the American Psychiatric Association's patron saint, Dr. Benjamin Rush, in 1786.

In 1973—in this year of doubt about morality in government and while the American citizenry questions the credibility of its leaders and holds its breath in suspense to see whether its republican system can steady itself in the face of unprecedented insults—it is timely that an essay on morality by a founding father of the nation, who happens also to be the father of American psychiatry, should be republished.

Under the title *Two Essays on the Mind* (1) APA Fellow Eric T. Carlson, M.D., has reproduced from the original printings two little-known lectures by Rush that reveal his thinking on the influence of physiological causes on the moral and intellectual faculties of man. Dr. Carlson has provided an introduction that places the works in their 18th-century perspective. Here was a signer of the Declaration of Independence who wanted to design a system of government that could endure all the faults and foibles of the men who participated in it, investigating the moral nature of man from a medical viewpoint.

The year 1786, when Dr. Rush delivered "An Enquiry Into the Influence of Physical Causes Upon the Moral Faculty" before a distinguished audience of the American Philosophical Society, which included Benjamin Franklin, was a turbulent year of monetary inflation and political crisis; it was after Yorktown but before the adoption of the United States Constitution. Rush felt that the time was right to submit to the leaders of government "this feeble effort to increase the quantity of virtue in our republic."

"I am aware," he said, "that in venturing upon the subject, I step upon untrodden ground." He was aware that medical writers had never before attempted to include disorders of the moral faculty in their system of nosology, and as a consequence physicians had not attempted to treat such disorders as medical conditions that might be improved or cured with proper remedies. His foray into the area of personality disorder became the pioneer American attempt both to study moral derangement and to regard it as a medical disorder deserving of treatment. For the first time, an American physician—not a preacher or a philosopher—claimed the subject of morality as his proper province.

In summary, Rush theorized that human beings are born with a moral faculty just as they are endowed with certain native intellectual faculties. The moral faculty is the power of the mind to choose good or evil, virtue or vice. The moral faculty should not be confused with conscience: "The moral faculty performs the office of a law-giver, while the business of conscience is to perform the duty of a judge." It can be affected by climate, diet, sleep, disease, music, and numerous other physical and social factors.

Rush considered that he "only performed the drudgery of a pioneer" in opening the subject to medical research, and he hoped that others would pursue it: "The moral faculty has been the subject of less culture and fewer experiments than the body, and the intellectual powers of the mind. . . . Should the same industry and ingenuity, which have produced . . . triumphs of medicine over diseases and death, be applied to the moral science, it is highly probable, that most of those baneful vices, which deform the human breast and convulse the nations of the earth, might be banished from the world." Rush did not consider it impossible that some day researchers might discover medicines that would influence the moral faculty: "May not the earth contain in its bowels, or upon its surface, antidotes to our moral, as well as natural diseases?"

It was his conviction that treatment could be effective. This led Rush in later years to write against capital punishment and on behalf of the rehabilitation of criminals. He founded the Pennsylvania Prison Society to promote prison reform. But he never believed that laws or prisons would promote virtue: "Laws for the suppression of vice and immorality will be as ineffectual, as the encrease and enlargement of gaols."

What would guarantee the proper development of the moral faculty in man? Rush had an answer: "There is but one method of preventing crimes, and of rendering a republican form of government durable, and that is by disseminating the seeds of virtue and knowledge through every part of the state, by means of proper modes and places of education." His advice to the guardians of American liberties was "to establish and support public schools." Only public education could guarantee that moral government would endure in a republic.

It is nearly 200 years since Rush opened the field of morality to medical enquiry. We physicians have not eagerly embraced it as our province. The day seems very distant when moral responsibility, and more particularly morality in government, will be within the purview of medicine. Rush would have encouraged us to move forward: "I am fully persuaded that . . . it is possible to produce such a change in the moral character of man, as shall raise him to a resemblance of angels." The simple, sometimes naïve, but perspicacious thoughts of our 18th-century psychiatric forebear are worth reflecting on today.

REFERENCE

1. Rush B: Two Essays on the Mind (facsimile reprint). New York, Brunner/Mazel, 1972

ROBERT E. JONES, M.D.

Dr. Jones is Associate Medical Director of the Institute of the Pennsylvania Hospital and Chairman of the Benjamin Rush House Committee.

BRIEF COMMUNICATIONS

Drug Treatment of Depressed Patients Referred for Hospitalization

BY JOEL KOTIN, M.D., ROBERT M. POST, M.D., AND FREDERICK K. GOODWIN, M.D.

The authors' clinical impression that many depressed patients are admitted to hospitals without having received adequate drug treatment as outpatients was confirmed with a sample of 51 depressed patients. Of these, only 20 percent had received proper drug treatment before referral. The authors propose a larger study of the actual patterns of drug prescription to seek the causes of inadequate treatment.

THE DEVELOPMENT of effective antidepressants has been one of the major psychiatric advances in the last quarter century. Yet it has been our experience in a number of different clinical settings—including university, public, and private hospitals—that many depressed patients are referred to hospitals without adequate trials of antidepressant medication as outpatients. There are several possible explanations: a physician's bias against drugs, the use of the wrong drugs, the use of inadequate dosages of the correct medication, or an emergency that requires hospitalization.

As a first step toward investigating this phenomenon, we undertook a retrospective study of 51 consecutive depressed patients who were admitted to our research unit that is studying affective illness. The study focused on the drug treatment that the patients were receiving at the time of their referral and their subsequent response to treatment in the hospital. This paper reports the results of the study and discusses possible explanations and remedies for the situation.

At the time this work was done, the authors were with the Section on Psychiatry, Laboratory of Clinical Science, National Institute of Mental Health, Bethesda, Md., where Dr. Kotin was Clinical Associate, Dr. Post is Special Research Fellow, and Dr. Goodwin is Chief, Clinical Research Unit. Dr. Kotin is now Assistant Adjunct Professor, Department of Psychiatry and Human Behavior, University of California at Irvine; his address is 1201 West LaVeta Ave., Orange, Calif. 92668.

METHOD

The charts of all patients who were admitted for depression over a two-year period (February 1970–February 1972) were reviewed to determine what drugs they were receiving before their admission and their response to the drugs they received in the hospital, and to obtain various demographic data. All patients met standard criteria for a diagnosis of primary affective illness (1); their level of depression at the time of admission ranged from moderately severe to severe (global depression rating of eight or more on a modified version of the 15-point Bunney-Hamburg scale [2]).

RESULTS

Fifty-one depressed patients ranging in age from 19 to 74 were included in the study. There were 28 women and 23 men. Twenty-nine were unipolar (no history of mania or hypomania) and 22 were bipolar (history of mania or hypomania).

The pattern of drug treatment at the time of referral to the hospital is summarized in table 1. Although 21 patients (41 percent of the sample) were receiving tricyclic antidepressants (imipramine, amitriptyline, or doxepin), only eight patients were receiving tricyclics at dosages of 150 mg./day or greater; 13 patients received dosages of 100 mg./day or less. The period during which the patients received antidepressant drugs varied in length considerably (five days to one year; mean=73 days), but this factor was not considered in evaluating the adequacy of this treatment. Of the 21 patients receiving tricyclics, 13 were also taking other psychotropic drugs. Of the 30 patients not receiving tricyclics (59 percent of the sample), nine were receiving psychotropic drugs that

TABLE 1
Drug Treatment of Depressed Patients at the Time of Their Referral (N=51)

Drug	Number	Percent
Tricyclic antidepressants*		
150 mg./day or more (including five patients taking additional psychoactive drugs)	8	16
50–100 mg./day (including eight patients taking additional psychoactive drugs)	13	25
Lithium carbonate (including one patient also taking phenothiazines)	2	4
Phenothiazines and/or other psychoactive drugs, excluding antidepressants	9	18
No medication	19	37

*Imipramine or amitriptyline, except in the case of one patient who had received doxepin.

are not ordinarily considered antidepressants (five were taking phenothiazines). Two patients, however, were receiving lithium carbonate. Nineteen patients were not taking any medications before admission.

The source of the referral (psychiatrists in private, clinic, or hospital practice, and physicians other than psychiatrists) did not seem to be related to the dosage of tricyclic that was prescribed. However, of the five patients referred by nonpsychiatrists, four were receiving drugs that are not ordinarily classed as antidepressants.

The following examples are typical of patients with severe depression who were treated with drugs other than antidepressants (case 1) or with low dosages of antidepressants (case 2) before hospitalization.

CASE REPORTS

Case 1. A 35-year-old attorney had been seen in psychotherapy sessions twice a week for more than two years for symptoms of depressed mood and inability to work. Nine months before his admission, his therapist had prescribed 300 mg. of thioridazine a day for agitation; he had later increased this to 400 mg./day. A psychiatrist on the NIH staff saw the patient in consultation and recommended hospitalization. On admission, the patient displayed a marked dyskinesia with a coarse tremor and dysarthria. All medications were discontinued after admission and within a week the tremor had disappeared, the patient's speech became normal, and his anxiety had decreased. The patient later responded to 250 mg. of imipramine a day after approximately ten days of treatment.

Case 2. A 27-year-old woman became depressed following the birth of her first child. She felt overwhelmed by her responsibilities, was disgusted by the soiled diapers, and resented the interruption of her career. She consulted a psychiatrist and was given 50 mg. of amitriptyline twice daily and thioridazine as necessary. Her depression worsened; two months later she was hospitalized and given six sessions of electroconvulsive therapy, with a "fair" response. Three months later she took an overdose of her medication and was again hospitalized. Shortly thereafter she was referred to NIH for more prolonged treatment. At NIH she remained depressed for two months while receiving intensive psychotherapy and lithium carbonate. After this period, she received 250 mg. of amitriptyline a day for three weeks and became much more positive about her abilities, her child, and her home situation. Her daily ward depression ratings improved significantly and she was discharged a week later after having her dosage reduced to 200 mg. of amitriptyline a day.

Only 35 percent of the patients in this study received tricyclic antidepressants while hospitalized at NIH, primarily because our current research focused on various experimental compounds and lithium. However, of the 18 patients who did receive tricyclic antidepressants, 12 responded,[1] an effect comparable to that reported in most studies (3).[2] Of the 12 in-hospital responders only two had had outpatient treatment at dosages of 150 mg./day or greater.

DISCUSSION

Evidence from a large number of controlled studies indicates that the tricyclic antidepressants imipramine and amitriptyline are in most cases effective in the treatment of moderate and severe depression only at dosages of 150 mg./day or greater (3). Of the 21 patients in our sample who received these drugs before their admission, only eight were receiving dosages in this range; 13 were receiving dosages of 100 mg./day or less.

Although there is some evidence that phenothiazines and related neuroleptics can be effective in relieving the agitation and anxiety that accompany some depressions (5), these compounds are not generally considered drugs of choice in the treatment of depression per se, especially if given alone. Nine patients in our sample were receiving these neuroleptic drugs without an accompanying antidepressant.

In drawing conclusions from these data, we have considered the treatment of moderate to severe depression to be "adequate" if patients were receiving tricyclic antidepressants at dosages of 150 mg./day or greater or were receiving monoamine oxidase inhibitors or lithium carbonate before their referral. Of the 51 depressed patients referred for hospitalization, only eight were receiving adequate tricyclic treatment and only two were receiving lithium. Therefore, by these criteria only ten patients (20 percent of our sample) were receiving adequate drug treatment for depression at the time of their admission. Twenty-two (43 percent) were receiving inadequate drug treatment and 19 (37 percent) were not taking medication.

Since the Clinical Center at the National Institutes of

[1] Nine of the 12 were unipolar; three were bipolar.

[2] Other antidepressant responses in the hospital included those of 17 patients who received lithium carbonate (these were predominantly patients with bipolar depression [4]), five who received electroconvulsive therapy, and one who received tranylcypromine. In the remainder of the sample, improvement was not clearly related to drugs.

THE AMERICAN JOURNAL OF PSYCHIATRY

Community Mental Health Services in Britain

BY DOUGLAS BENNETT, M.D., D.P.M.

Although the practice of psychiatry was similar in the United States and Britain during the last century, since then their paths have diverged, especially since the Second World War and the institution in Britain of the National Health Service. The major postwar development in Britain has been in social psychiatry, with particular reference to hospitalized psychotic patients. More recently, plans have been made to close mental hospitals and shift the locus of inpatient care to the general hospital. Projections have been made to provide services on a sector basis, in which teams of psychiatrists, nurses, and social workers serve population groups of 60,000 each and provide outpatient and transitional facilities as well as inpatient care. The author compares the different approaches in the United States and Britain and notes that, while neither can provide an ideal service, both can learn much from the differences.

WHEN WE IN BRITAIN use the word "community" in a mental health context, we are referring to care given outside the mental hospital in the mythical world of well people (1). We may include, too, the prevention of hospital admission and the idea of district or sectorized care. In the United States, "community" in a mental health context seems to have more to do with localism and the idea that services are better managed at the community level. I have heard it suggested that this view, which may have been inherited from Utopian thinkers of the 18th century, now reflects a dislike of the direct provision of services by the state (2). Whether that is so or not, it does emphasize the fact that since "community mental health" is deeply rooted in the history and the beliefs of our respective societies, it also has different meanings for both of us.

In trying to explain something of community mental health in my country I must try to make these differences clear. But I shall also try to avoid dangerous comparisons, for in the worldly wisdom of Samuel Johnson, "by exciting emulation and comparisons of superiority, you lay the foundations of lasting mischief; you make brothers and sisters hate each other." That I do not want to do.

Read as a special lecture at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

Dr. Bennett is Psychiatrist, the Bethlem Royal Hospital and the Maudsley Hospital, Denmark Hill, London SE5 8AZ, England.

OUR INHERITANCE

In the 19th century the practice and problems of psychiatry were very similar in our two countries. We both had our reformers. You had Dorothea Dix, who believed in the value of the mental hospital. We had John Conolly, who, by abolishing physical restraint, did much to improve our care of the mentally ill. Many before him had thought that the physical restraint of the mentally disordered could and should be reduced, but no one thought that it was possible to abolish it completely (3). Conolly's action in doing this led to great controversy, for he was eager that the mentally ill should be treated with the same good intentions as doctors treated the physically sick. Whatever we think now about equating mental disorder with illness, at that time it did much to better the social position and to increase the freedom of the mentally sick. So it is not surprising that Conolly also believed that mental disorders should be treated, whenever possible, outside the mental hospital. It took some time for his ideas to be accepted and their full impact had to wait on later social changes; I cannot tell the whole story.

In the latter part of the last century and in the first half of this one, matters moved forward rather sedately. Then the shared dangers and experiences of the Second World War drew people of all classes in our society closer together. By the end of the war it was accepted that it was the proper function of government to ward off stress and strain not only among the poor but among all classes of society. Sir William Beveridge's plan to combat the evils of want, disease, ignorance, squalor, and idleness was implemented in a series of enactments that led to what we now call the Welfare State. In an attempt to deal with

disease, the National Health Service was established as one limb of this body.

Some see our Welfare State as helping the disadvantaged to make good; others see it as undermining people's self-sufficiency by state handouts. But whatever one's opinion of its effect on the wider society, its egalitarian philosophy of "bread for all before cake for anybody" has had a very considerable influence on the provision of services for the mentally ill. In the National Health Service, which came into being in 1948, psychiatrists (like other doctors) were salaried. They received the same pay as the surgeons and internists wherever they worked. The service brought all the hospitals, whether general or mental, formerly managed by local bodies, under the same regional and national direction. As soon as these hospitals were administered side by side the difference in the quality of care given to the mentally disordered and the physically ill was shown up in bold relief. Also, the difference in the terms under which people were eligible for treatment was so great that quite soon the whole question of legal commitment was referred to a Royal Commission (4).

Their enquiry and recommendations led to a new Mental Health Act, which was passed by Parliament in 1959. This act made it possible for the mentally ill person who could accept the role of patient to be admitted to a hospital without the formality of commitment. Committal, when needed, was no longer a quasijudicial process. Instead, two doctors, one a qualified psychiatrist, had to explain why care or treatment was needed and why the individual could not be treated in the role of a voluntary patient. Today less than 17 percent of admissions to our psychiatric hospitals are compulsorily committed, and only six percent of hospital residents are detained in this way. The Royal Commission also stated the view that greater efforts should be made to avoid hospital admissions. Its report gave official recognition to those community psychiatric services which had already been developed up and down the country and encouraged a further use of out-of-hospital care.

PRESENT THINKING

In the words of one American visitor: "The major postwar development in British psychiatry has been in social psychiatry, with particular reference to psychotic patients in hospital. By contrast, in the United States, a major development has been in so-called dynamic psychiatry, with particular reference to ambulatory neurotic patients" (5). Knight Aldrich thought, quite rightly, that our pattern of care was a direct outcome of the National Health Service, an origin that has influenced its subsequent development.

Since both the mental hospitals and the general hospitals are managed by the same regional hospital boards, the planning of community psychiatry services has been undertaken in a medical context. This was Ministry of Health policy, and in 1960 its Chief Medical Officer, Sir George Godber, urged that "if the opportunity for bringing psychiatry fully into the general pattern of medicine which now presents itself is grasped, the new attitudes created both within the profession and in the public mind, will do more for mental health than any other single measure" (6).

At that time the Ministry of Health was encouraging the development of psychiatric outpatient, day-patient, and inpatient services in general hospitals but still thought that a substantial part of hospital psychiatric work would have to be undertaken in the traditional mental hospital. More recently the department has decided that improvements in treatment and care allow us to replace the large separate mental hospitals with a service based in the general hospitals. This is a dramatic change in policy. In such a service the general hospital psychiatric unit will combine with the other two parts of our three-part health service—that is, the family doctor and public health sectors—to provide comprehensive psychiatric care to a defined district. The Department of Health intends that these facilities should be used as flexibly as possible and that emphasis should be given to rehabilitation and to the preservation of continuity in the patient's personal relationships and his contacts with his local community (7). There are hopes that these three parts of the medical services can plan more effective comprehensive care when, next year, they are merged and administered by area health boards.

This is the rhetoric; you may wonder by how much it is separated from reality. There is of course a gap, but it may be narrowing rather than widening. It should be filled in part by a newcomer to our services: the social services department of the local authority. This new body grew out of the appreciation by the social workers and government that the existing social services were responsible only for certain types of social problems and the difficulties of particular age groups (8). It was felt that human needs could not be categorized in such an arbitrary fashion in spite of the realization that medical care, education, and housing all have social components. So it was decided that social workers should give up such former specialisms as mental health, child care, and welfare and merge these into one department providing a unified family service. Social workers accepted this, integrated their professional associations and their differing trainings, and, when sanctioned by the Social Services Act of 1971, took charge of their own departments in the local authorities.

While some people regret the disappearance of the former mental health and psychiatric social workers, the new departments provide a useful social counterpoise to our medically oriented psychiatric services. But the departments are young and are preoccupied with their own internal problems, so it will be some time before the social workers can make their full contribution to community mental health. Meanwhile, many psychiatrists say that the removal of social workers from the medical orbit has made effective cooperation impossible (9). Since there are plenty of examples of fruitful cooperation between psychiatrists and social service departments, these remarks only show that many doctors do not know how

to work for and with social workers. The doctor's outlook has some importance, for the next stage of our planned development is the closing of the mental hospital, and that requires teams of social workers, psychiatrists, and others to work together to meet the needs of a specified population. The administrative discontinuity between health and social service departments must make teamwork difficult, although with the right attitudes this could be overcome.

CLOSING THE MENTAL HOSPITAL

The arguments for closing the mental hospital have never been very clearly stated. In the 1950s community care was seen as preventing admission, or, failing that, securing the patients' early discharge from the hospital. Such a policy was community minded only in the sense that it was anti-institutional. Not surprisingly, a comparative evaluation of three dissimilar services, including a community service with a worldwide reputation, did not confirm the value of this limited type of community care (10). In spite of this as well as great and well-known achievements of some of our mental hospitals, they have remained the villain of the piece in community mental health. Many people feel that the continuing accumulation of patients in these ghettos has cast a shadow over all our services and mocks our therapeutic pretensions.

Some argue that we cannot get rid of our mental hospitals before we have adequate alternative services. Certainly we have an increasingly clear idea, in numerical and other terms, of the alternatives that are needed (11). Others believe that alternative services will not be provided as long as the mental hospital remains as a convenient way to dispose of difficult problems.

We know that as long as we have mental hospitals we are unlikely to prevent admission to them. Hopes that this would happen have always overlooked one important aspect of psychiatric care: the desire of mental health professionals to get rid of undesirable patients. This distinction is almost unique to psychiatry and reflects an intolerance rooted in the inability of doctors and others to deal with their own feelings, whether of hostility, anxiety, or a sense of failure (12).

There are many ways of tackling the problem, but the fundamental solution is that professional staff members have to give up the right to refuse referrals and the right to refuse to refer people to other services (13). In practice, undesirable patients are referred in only one direction, whose final destination is the mental hospital. Elimination of the mental hospital does not solve the problem entirely, for with or without the mental hospital, both doctors and social workers may refer unwanted patients to colleagues with lower status or less training (14). But the taking apart of mental hospitals will force the staff to look for other solutions and to rethink the real nature of psychiatric care.

Part of the hospital dismantling happens naturally, for in our country, as in yours, there is a steady attrition of long-stay hospital patients by discharge or death and only a slow accumulation of new chronic patients (15). Simultaneously, new patients have to be diverted to other services and in particular to the district general hospital. There are dangers for the mental hospital. The knowledge that the hospital is going to close can lead to a sharp decline in staff morale, which results in a deterioration in standards of care. To avoid this it is proposed that the mental hospital's catchment area should be split into geographical districts of 60,000 population. Then each district will be served by a team made up of district general hospital and mental hospital staff members and social workers from the new departments. The beds and day places in both the mental hospital and the district general hospital will be divided, so that each team has day places and beds in both situations (7). When eventually the new general hospital psychiatric department can provide all the necessary services, the few patients remaining in the mental hospital will be transferred to another mental hospital whose closure program is less advanced. This is an ambitious plan and progress must be slow, for evolution, not revolution, is the aim. Even so, reaction—especially from doctors—has been quite brisk.

DOUBTS AND DIFFICULTIES

In such a situation reality and rhetoric tend to drift apart. I have already introduced you to what Titmuss (16) called "that exotic hothouse climbing rose, 'the welfare state,' with its lovely hues of tender pink and blushing red, rampant and rampaging all over the place, often preventing people from 'standing on their own feet,' in their own gardens." He went on to wonder whether the everlasting cottage garden trailer "community care" did or did not conjure up a sense of warmth and human kindness essentially personal and comforting. It may have done so, but it has conjured up controversy and criticism too. Doctors hold strongly partisan views for or against community psychiatry; these have been thought to have a distinctly American flavor (17). But these views are equally evident in Britain. I suspect that the flavor is neither British nor American, but medical.

The public, on the other hand, seems to welcome the community approach. They have always cared for the mentally ill, and it is only in quite recent years that they have begun to trust the mental hospitals to do this for them. Of course the mentally ill were not always well cared for outside the hospital. However, a national opinion poll in 1971 showed strong public support for undertaking the care of the mentally ill in the community (18). Six out of every ten people interviewed thought that the mentally ill should be encouraged to lead a normal life. At the same time, the public openly discusses and criticizes conditions in mental hospitals that previously were not mentioned in the press (19). Meanwhile some psychiatrists, seemingly forgetful of recent scandals, revive nostalgic memories of mental hospital gardens with their flowers and green lawns and speak of them as a sanctuary for patients (20).

While the debate continues, community psychiatry has

not provided a ready banner for those in our islands demanding social change or marching in a radical activist cause (21).

More substantial doubts have been expressed about the government's plans. The statistical projections of change in bed needs and the experiences of a few community services are critically questioned, for it is on these rather doubtful data that the plan seems to be based (22–24). The success of the plan in its present form depends on certain assumptions "which have not yet been tested; that very few patients will in future become severely handicapped psychiatrically, that those who do so will either not require residential care or can be looked after adequately by the social services and that the disadvantages apparently inherent in the mental hospital system will not be inherent in any system which replaces it" (11).

It does seem that the number of hospital beds allowed in the plan may be too low. It seems, too, that little or no thought has been given to the needs of that small number of patients, mostly with schizophrenia or organic mental syndromes, who still become handicapped in spite of all we do. Obviously there will be difficulties in establishing effective cooperation between psychiatric units in the district general hospitals and the new social service departments that, between them, will have to provide the shelter and the rehabilitation services that were the mental hospitals' special contribution to the care of chronic patients. There are doubts, too, not only about how they will cooperate, but how each will meet its own responsibility. Some wonder whether the social service departments can provide these facilities, or whether they can provide them in time.

It is important that the provision should be kept in phase with the transfer of medical services from the mental hospital to the district general hospital. Doctors doubt whether the general hospital, for its part, can cope with patients whose problems are difficult or chronic. It is assumed that because general hospitals have dealt only with the less severely ill, that is all they can do. This is not so, but of course they will have to change their ways of functioning and they will need support from other services as well as accommodation in hostels, boarding houses, and day centers for those with permanent handicaps.

THE PRESENT SITUATION

It is unlikely that the scheme in its present form will meet all these needs, and evaluation of the services is essential. There is ongoing evaluation of some developing services, and other evaluations are projected (11). The findings, taken together with the experience of clinicians, should lead to later modifications of the government's policy.

It will be clear from this account that our present mental health services are still largely centered on the hospital and the psychiatrist. Our major aims are the prevention of chronic patienthood and the closing of the mental hospital, rather than primary prevention, consultation, and crisis intervention. This outlook is in part an expression of our pragmatism and in part determined by the history and the logic of our situation. Having recognized that with the means at our disposal we could not prevent mental illness or prevent some patients from developing very severe handicaps, we decided that we would deal with what was within reach not only of our understanding but of our resources. In time we shall do more for mental health than for mental illness and be more interested in communities than hospitals. At present, manpower is limited and so are budgets; this has an effect on what is done.

There will be three psychiatrists (and only one of those a senior) for the population of 60,000 persons that is the basic unit in our planning. This population will yield about 500 patients who are in our care at any one time while approximately another 500 people, 215 of them inpatients and about 265 outpatients, will come into care each year (25). They will be supported by hospital and public health nurses and by social workers. There will also be about 24 family doctors in the area. These doctors, however, cannot give psychiatrists much help, for in our health service family doctors are already seeing the bulk of the patients with socio-emotional problems (26). These patients suffer mostly from minor affective illnesses that are associated with various forms of social difficulty (27). The family doctor's interest in his patients' socio-emotional difficulties and his capacity to deal with them are closely related, whether by cause or effect, to the size of his practice (28). He refers those with the more difficult and time-consuming problems to the psychiatric outpatient departments and is often reluctant to support them after they are discharged from the hospital. Many solutions have been proposed: these include giving family doctors more education and understanding of socio-emotional problems and reorganizing their practices on a group basis with social workers attached. While matters are slowly changing, we know that many family doctors are still not keen on working with social workers (29).

When people suggest, as many do, that we cannot meet the requirements of a community-based mental health service with our present resources, they overlook the fact that the redeployment of these resources, if it does not improve the situation greatly, is unlikely to worsen it. Staff morale can have a considerable effect, and it seems clear that the morale of mental health personnel is higher when they work outside mental hospitals. At the same time we are uneasily aware of the increasing demand on services that are separate from mental hospitals. Also, the scope of psychiatry's responsibilities is more broadly defined. It is no longer enough to provide for the needs of the mentally ill, the mentally retarded, and disturbed children. We have to provide more service for mentally disturbed offenders, mentally infirm old people, alcoholics, drug addicts, and those who attempt suicide and self-poisoning.

It seems obvious that if we are to meet all these new demands, our tasks and responsibilities will have to be reallocated. A service based on sectorized care has certain advantages in this respect, for the sector defines the responsibility of psychiatrists and others who have to

share the patients' care. It forms a base for cooperation with families and with a range of services providing social help whose very existence is undreamed of by many hospital psychiatrists. Even today, district services have provided some working or living environments for those persons who are severely handicapped by mental illness and who lack family support. There are not enough, but they are there and provision for them is growing. Of course, sectorization does not ensure that the psychiatric and social services will cooperate. So much has been said and written about continuity of care, cooperation, coordination, and teamwork that the words have all but lost their meaning. They do not tell us how to work or what to do. They provide no basis for teaching psychiatrists. Many still think that community psychiatry is nothing more than keeping the patient out of the mental hospital, giving first aid care, talking to a social worker, or sending the patient to a day hospital. Some believe that community services allow psychiatrists to escape the painful business of facing up to the patient's problems. Nothing could be farther from the truth.

THEORY AND RESEARCH

There is much more to community mental health services than their administrative structure. It takes more than goodwill, common sense, and enthusiasm to provide effective help. Meyer Gross said many years ago that "advances in mental health are not made by administrative dodges or by giving new names to old problems." Some old problems are always with us, and none is more teasing than the balance of advantage and disadvantage between treatment in the hospital or in the community. There is no right or wrong solution, only better or worse decisions for certain people, at certain times, and in certain circumstances. Yet we cannot learn how to make those decisions, modify our services, or teach others unless we have a sound basis in theory and research. While community psychiatry must have a practical base in a sectorized service, its theoretical foundation is in social psychiatry. Sabshin brought these two facets together when he said that community psychiatry uses social psychiatry's techniques, theories, and methods, as well as those of the other behavioral sciences to meet the mental health needs of a defined population over a significant period of time (17).

It is one of the little-known strengths of the British community mental health service that we have a small but influential group of research workers in social psychiatry. Their work grew out of the Medical Research Council's Social Psychiatry Research Unit, which was founded by Sir Aubrey Lewis in 1948—the same year that the National Health Service was established. Their research and their names are well known (30). They have influenced plans and policies and have provided guidelines in matters of patient management, rehabilitation, and social treatment.

It is still difficult to attract first-class clinicians from the hospital to community mental health. The view that they will come to us only when they see that community mental health has scientific substance is reflected in the remarks made by a young American lecturer working with us. "It is this emphasis on the scientific validation of delivery systems and treatment techniques which lends respectability to the movement and makes community psychiatry a proper pursuit within the university" (31). But trainees must not learn only about community and social psychiatry. They have to learn to be community psychiatrists. Training in community psychiatry requires that the student work in a situation where the patient and his family remain the staff's responsibility over a considerable period of time. The community psychiatrist does not learn by working in private with highly selected patients who are "his" alone. He has to learn through the sobering experience of sharing with a team the care of those who may be poor, unintelligent, or poorly motivated or who may fail to improve with treatment (32). The knowledge that there is no escape from this responsibility and that the team's failure to help the patient involves them in his long-term care concentrates the mind wonderfully and leads to more ingenious and useful solutions. The resulting growth of staff confidence and competence is another factor that is rarely taken into account yet is crucial to the future function of our community mental health services.

In Britain, at least, community psychiatry is not a soft option, offering "less painful jobs at higher salaries, with high sounding titles, plus opportunities for community contact, the novelty of newspaper interviews and speech making" (33). I doubt whether it is like that in America either. For wherever we work, our methods differ and our failings and our excellences differ. Neither of our two countries can provide the ideal service. One hopes that we can learn something from our differences.

REFERENCES

1. Vickers G: Community medicine. Lancet 1:944–947, 1967
2. Cumming E: Community psychiatry in a divided labor, in Social Psychiatry. Edited by Zubin J, Freyhan F. New York, Grune & Stratton, 1968, pp 100–113
3. Bennett DH: One hundred years after John Conolly. Proc R Soc Med 60:89–92, 1967
4. Department of Health and Social Security: Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, Command 169. London, Her Majesty's Stationery Office, 1957
5. Aldrich CK: Psychiatry consultation in general practice. Lancet 1: 805–808, 1965
6. Department of Health and Social Security: Annual Report of Chief Medical Officer, Command 1550. London, Her Majesty's Stationery Office, 1960
7. Department of Health and Social Security: Hospital Services for the Mentally Ill, Hospital Memorandum 97. London, Her Majesty's Stationery Office, 1971
8. Department of Health and Social Security: Report of the Committee on Local Authority and Allied Personal Social Services, Command 3703. London, Her Majesty's Stationery Office, 1968
9. The Mental Health Service After Unification, Report of the Tripartite Committee of Royal College of Psychiatrists, Society of Medical Officers of Health, and the British Medical Association. London, British Medical Association, 1972
10. Brown GW, Bone M, Dalison B, et al: Schizophrenia and Social Care, Maudsley Monograph 17. London, Oxford University Press, 1966

11. Wing JK, Hailey AM (eds): Evaluating a Community Psychiatric Service: The Camberwell Register 1964–71. London, Oxford University Press, 1972
12. Hill D: Psychiatry in Medicine: Retrospect and Prospect. London, Nuffield Provincial Hospitals Trust, 1969
13. Cumming E: Three issues affecting partnerships among mental health agencies. Hosp Community Psychiatry 22:33–37, 1971
14. Rudolph C, Cumming J: Where are additional psychiatric services most needed? Social Work 7:15–20, 1962
15. Hailey AM: Longstay psychiatric inpatients: a study based on the Camberwell Register. Psychol Med 1:128–142, 1971
16. Titmuss RM: Community care: fact or fiction? in Trends in the Mental Health Service. Edited by Freeman H, Farndale J. London, Pergamon Press, 1961, pp 293–318
17. Sabshin M: Theoretical models in community and social psychiatry, in Community Psychiatry. Edited by Roberts LM, Halleck SL, Loeb MB. Madison, University of Wisconsin Press, 1966, pp 15–30
18. The muddled approach to sick minds. London, Sunday Times, Oct 11, 1971, p 7
19. Department of Health and Social Security: Committee of Inquiry Into Conditions at Whittingham Hospital, Command 4861. London, Her Majesty's Stationery Office, 1972
20. Back to the "Bin"? Lancet 1:527–528, 1973
21. Goldberg D: The scope and limits of community psychiatry. Modern Problems of Pharmacopsychiatry 6:5–25, 1971
22. Baker AA: Psychiatric illness in a district general hospital. Lancet 1:1090–1092, 1969
23. Oldham AJ: Community psychiatry in London: a three-year analysis. Br J Psychiatry 115:465–474, 1969
24. Tooth GC, Brooke EM: Trends in the mental hospital population and their effect on future planning. Lancet 1:710–713, 1961
25. Birley JLT: The ghost in the machine, in Policy for Action. Edited by Cawley R, McLachlan G. London, Oxford University Press, 1973, pp 103–109
26. Shepherd M, Cooper B, Brown AC, et al: Psychiatric Illness in General Practice. London, Oxford University Press, 1966
27. Cooper B: Social correlates of psychiatric illness in the community, in Approaches to Action: A Symposium on Services for the Mentally Ill and Handicapped. Edited by McLachlan G. London, Oxford University Press, 1972, pp 65–70
28. Mechanic D: Practice orientation among general medical practitioners in England and Wales. Med Care 8:15–25, 1970
29. Harwin BG, Cooper N, Eastwood MR, et al: Prospects for social work in general practice. Lancet 2:559–561, 1970
30. Shepherd M, Davis DL (eds): Studies in Psychiatry. London, Oxford University Press, 1968
31. Cavanaugh JL: Rehabilitation and Chronic Mental Illness, British Models. Philadelphia, 1971 (processed)
32. Mesnikoff AM: Urban psychiatry: effects on the psychiatric institute, in Urban Challenges to Psychiatry. Edited by Kolb LC, Bernard VW, Dohrenwend BP. Boston, Little, Brown and Co, 1969, pp 221–225
33. Kubie LS: Pitfalls of community psychiatry. Arch Gen Psychiatry 18:257–266, 1968

Questions of the Month

Directions: Each of the incomplete statements below is followed by four or five completions. Select the *one* that is BEST in each case.

Question 1 The sudden and repeated cessation of a person's train of thought or speech in the middle of a sentence (blocking) is most characteristic of
(A) children in latency (7–11 years)
(B) psychotically depressed patients
(C) schizophrenic patients
(D) patients with Korsakov's disease
(E) patients with manic-depressive psychosis

Question 2 Myoclonic jerks or generalized convulsions with paroxysmal activity on the electroencephalogram may be observed prior to drug withdrawal when high daily dose levels have been attained during chronic intoxication with
(A) heroin
(B) methadone
(C) cocaine
(D) pentobarbitol (Nembutal)
(E) meperidine (Demerol)

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 1081. The references for the questions are supplied on page 1117.)

Epidemiological Differences Between White and Nonwhite Suicide Attempters

BY ANDREAS M. PEDERSON, PH.D., GEORGE A. AWAD, M.D., AND ALAN R. KINDLER, M.B.B.S.

Using the Monroe County (N.Y.) Psychiatric Case Register, a stable data source, the authors attempted to determine differences between white and nonwhite suicide attempters, to identify the factors that are associated with self-destructive behavior in both groups, and to determine the subsequent mortality rate among suicide attempters. They found a number of differences between whites and nonwhites and conclude that the motivation for suicide, the techniques used to treat attempts, and the degree of risk of further psychiatric difficulty may be different for the two groups.

DURING THE PAST SEVERAL YEARS an increasing amount of research on suicide and suicide attempts has been conducted (1). Many of these studies have focused on the relationship between suicide and suicide attempts (2, 3), while others have focused on the clinical course and outcome of persons who have attempted suicide (4). A number of these studies have outlined basic demographic characteristics and some psychological factors associated with people who attempt suicide; however, the epidemiological study of suicide attempts is one major area of investigation that has only recently begun to be examined systematically (5).

Although our knowledge about suicide attempts has increased considerably, a number of questions about the factors associated with persons who attempt suicide remain unanswered. Part of this is due to the unreliable data collection systems that are used to record attempted and accomplished suicides in most communities. Another problem is that many of the previous studies on suicide attempts have used relatively small or highly selected samples. For example, most have included only those suicide attempts which have been identified by admission to general hospitals or by reports to the police. Because of the variability in data collection systems and because different sample selection procedures have been used, conclusions based on comparisons of these studies are of limited validity.

Further, while there is evidence to suggest that patterns of suicide attempts and characteristics of attempters are different in white and nonwhite populations (6, 7), little work has been done to investigate these differences in a systematic manner. These differences could produce considerable variance in studies of attempted suicides, particularly with certain types of sample selection procedures. More importantly, however, if race is not examined as a separate factor, true differences between white and nonwhite groups, which may indeed be helpful in understanding attempted suicides, may go unnoticed.

We attempt in this paper to clarify some of the problems found in previous research through an epidemiological study of suicide attempts in a relatively stable population over a four-year period. By examining the differences between white and nonwhite suicide attempters and outlining the demographic characteristics of suicide attempters, we hope to identify the characteristics associated with high-risk groups in terms of self-destructive behavior and to provide some insight into the underlying motivations for a wide range of self-destructive and potentially suicidal behavior. In addition, we will investigate the number of deaths among these suicide attempters in a five-year follow-up period, looking particularly at those deaths attributed to suicide.

METHOD

The sample consists of all consecutive suicide attempters treated in the emergency department of Strong Memorial Hospital during the years 1964 through 1967. Strong Memorial Hospital, the teaching hospital of the University of Rochester School of Medicine and Dentistry, is the largest general hospital in Monroe County, New York. During this study period the average yearly number of patient contacts in the emergency department was about 55,000. Every suicide attempter or suspected attempter who was treated in the emergency department was seen by a psychiatric resident before discharge. This contact was then reported to the Monroe County Psychiatric Case Register.

The Monroe County Psychiatric Case Register was used to identify the characteristics of the suicide attempters seen during the study period. The register was started on January 1, 1960, and nearly every psychiatric contact made in Monroe County has been reported to it since

At the time this work was done, the authors were with the Department of Psychiatry, University of Rochester School of Medicine and Dentistry, 260 Crittenden Blvd., Rochester, N.Y. 14642, where Dr. Pederson is Assistant Professor of Psychiatry and Psychology and Drs. Awad and Kindler were residents in psychiatry. Dr. Awad is now Associate, the Clarke Institute of Psychiatry and the Psychiatric Service of the Provincial Court (Family Division), Toronto, Ont., Canada, and Dr. Kindler is Associate, Department of Psychiatry, University of Toronto.

The Monroe County Psychiatric Case Register was supported from 1960 to 1969 by Public Health Service grant MH-00381 from the National Institute of Mental Health and is currently supported by the New York State Department of Mental Hygiene, the Monroe County (New York) Board of Mental Health, and the University of Rochester. This work was supported in part by these funds and by Public Health Service grant MH-08469 from NIMH.

then (8). In addition to basic demographic data about each patient, diagnoses, including the designation "suicide attempt," are recorded for each psychiatric contact, along with an indication of the presence or absence of previous psychiatric care. The register also records the deaths and their causes for every person who has been reported. This procedure creates not only a continuing psychiatric register but also a continuing and updated death register. In the register, race is categorized as white or nonwhite. The white group includes all Caucasians and most of the Puerto Rican and American Indian ethnic groups, while the nonwhite group is composed almost exclusively of people of Negroid ancestry. The socioeconomic level of a person who is reported to the register is defined by the census tract in which he lives. Each census tract in Monroe County has been classified into one of five groups (from I at the highest to V at the lowest) on the basis of a composite index of social and economic factors. These factors and the method of classification have been described elsewhere (9).

Out of 219,233 emergency room contacts at Strong Memorial Hospital during the study period (1964 through 1967), 1,345 persons were seen as the result of a suicide attempt. While there were five other hospitals with emergency services in the Rochester-Monroe County area during the study period, Strong Memorial Hospital had nearly twice as many emergency room contacts per year as any other, and it was the only hospital that had a psychiatric facility in the emergency department. Because of its range of services and psychiatric facilities, most suicide attempts in the county area were referred to Strong Memorial Hospital. Examination of the emergency log from another large general hospital, which ranked third in the number (121, 266) of total emergency room contacts during the study period, revealed that only 125 suicide attempts had been treated in its emergency department.

Unlike samples used in many other studies of suicide attempts, this sample has the advantage of including all consecutive suicide attempts seen in an emergency department; it consequently provides a wider range of suicidal behaviors, from the mild suicide gesture to the relatively serious attempt. Also, because most of the suicide attempts in the county were treated at Strong Memorial Hospital, the sample is fairly representative of all suicide attempts made throughout the county.

TABLE 2
*Age-Specific Average Annual Rates for Suicide Attempts by Race and Sex**

Age Group	White		Nonwhite	
	Male	Female	Male	Female
0–14	1	2	10	5
15–24	90	238	153	803
25–44	49	129	67	436
45–64	21	44	0	87
65 and over	18	13	0	62
Crude rate	29.91	74.34	48.82	266.08

*Rate is the number of attempts per 100,000 based on the 1960 census of Monroe County.

RESULTS

Of the 1,345 suicide attempts recorded at Strong Memorial Hospital during the study period, 335 (25 percent) were made in 1964, 347 (26 percent) in 1965, 313 (23 percent) in 1966, and 350 (26 percent) in 1967; the yearly average number of suicide attempts was 336. The total number of completed suicides in Monroe County for the four-year period (obtained from county health statistics) was 244, an average of 61 per year. The ratio of suicide attempts treated in our emergency department to completed suicides for the four-year period was 5.5:1. These figures represent an annual rate for suicide attempts treated at Strong Memorial Hospital's emergency department of 57.30 per 100,000 and a county suicide rate of 10.4 per 100,000 for each year of the study period.

Table 1 presents the total group of suicide attempters by age, race, and sex. Eighty-eight percent (1,186) of the total sample were white and 12 percent (159) were nonwhite. Women accounted for 74 percent (1,000) of the total. Eighty-four percent (1,128) fell within the group aged

TABLE 1
*Suicide Attempts by Age, Race, and Sex**

Age Group	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0–14	5	1	7	1	2	9	1	1	15	1
15–24	110	34	327	38	10	45	63	46	510	38
25–44	141	44	400	46	10	45	67	49	618	46
45–64	48	15	111	13	0	0	5	4	164	12
65 and over	19	6	18	2	0	0	1	1	38	3
Total	323		863		22		137		1,345	

*The distribution by race and sex for the 1960 census of Monroe County was: white males = 46 percent, white females = 50 percent, nonwhite males = 2 percent, and nonwhite females = 2 percent.

TABLE 3
Suicide Attempts by Socioeconomic Level, Race, and Sex

Socioeconomic Level	Percentage of Total County Population	White				Nonwhite				Total	
		Male		Female		Male		Female			
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
I	12	21	7	80	9	0	0	1	1	102	8
II	26	67	21	209	24	2	9	2	1	280	21
III	43	133	41	359	42	1	5	17	12	510	38
IV	12	74	23	168	19	8	36	53	39	303	23
V	5	28	9	45	5	11	50	62	45	146	11
Unknown		0	0	2	1	0	0	2	1	4	<1
Total		323		863		22		137		1,345	

15 to 44. In the white group, 73 percent (863) were women and 27 percent (323) were men, a ratio of approximately 3:1. However, in the nonwhite group, 86 percent (137) were women and only 14 percent (22) were men, a ratio of 6:1, which is quite different from that of the white group. Age also differentiated the white from the nonwhite group. While 82 percent (978) of the whites were between 15 and 44 years old, 94 percent (150) of the nonwhites were in that age range. There was no nonwhite man older than 45 in the study group.

Table 2 presents the age-specific average annual rates for suicide attempts by race and sex. The combined rate for whites was 52.91 and that for nonwhites was 159.57; the overall crude rate was 57.30. In every age group where nonwhite suicide attempts were recorded, the rates were higher for the nonwhites than for the whites. This is especially obvious for the nonwhite women in the groups aged 15 to 44. Even when the overall rates were adjusted for age, the differences remained; the age-adjusted rate for nonwhite women (268.12) was nearly four times that of white women (74.19), and similarly the rate for nonwhite men (44.87) was approximately 1.5 times the rate for white men (29.68). In some cases, the reported rates are based on relatively small frequencies, since only a few suicide attempts were recorded in some age groups and the total number of nonwhite suicide attempts was relatively small in terms of overall frequency.

Table 3 presents the socioeconomic levels of the suicide attempters in the sample. As can be seen, levels IV and V were overrepresented. These two levels accounted for 33 percent (449) of the attempters but represented only 19 percent of the total county population. Although socioeconomic levels I and II accounted for 38 percent of the total county population, only 28 percent (382) of the sample was from these two levels. In the white group, persons from socioeconomic levels IV and V represented 27 percent (315) of the attempts, while in the nonwhite group 84 percent (134) were from these two levels. In contrast, socioeconomic levels I and II accounted for 32 percent (377) of the white attempters but only three percent (five) of the nonwhites.

The relationship of marital status, race, and sex of the suicide attempters is presented in table 4. Examination of the marital status in terms of race and sex revealed that only 38 percent (61) of the nonwhite suicide attempters were married compared with 50 percent (594) of the white group. Among nonwhite men, 55 percent (12) of the suicide attempters were single and among the nonwhite women 28 percent (39) were separated. These two rates are in marked contrast to those for the white group and appear to account in large part for the different rates of married people in the white and nonwhite groups.

The relationship of psychiatric diagnosis given at the time of the suicide attempt to race and sex is presented in

TABLE 4
Suicide Attempts by Marital Status, Race, and Sex

Marital Status	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Single	121	37	269	31	12	55	40	29	442	33
Married	155	48	439	51	8	36	53	39	655	49
Separated	25	8	79	9	1	5	39	28	144	11
Divorced	14	4	60	7	1	5	4	3	79	6
Widowed	8	2	16	2	0	0	1	1	25	2
Total	323		863		22		137		1,345	

TABLE 5
Suicide Attempts by Diagnosis, Race, and Sex

Diagnosis	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Schizophrenia	48	15	80	9	1	5	8	6	137	10
Affective psychosis	21	7	29	3	1	5	3	2	54	4
Chronic brain syndrome	10	3	8	1	0	0	3	2	21	2
Neurosis	86	27	250	29	8	36	38	28	382	28
Character disorder	106	33	319	37	7	32	53	39	485	36
Other	22	7	110	13	4	18	18	13	154	11
Suicide attempt only	30	9	67	8	1	5	14	10	112	8
Total	323		863		22		137		1,345	

table 5. Individuals who had a diagnosis of psychotic disorder (schizophrenia, affective psychosis, or organic brain syndrome) represented 16 percent (212) of the total group. The diagnoses of neurotic disorders or character disorders made up 64 percent (867) of the total sample. Most of the 11 percent (154) classified as "other" received a diagnosis of adjustment reaction. For the remaining eight percent (112), there was no psychiatric diagnosis other than the recorded suicide attempt. Examination of the relationship of diagnosis to race revealed that for the total group of suicide attempters the diagnosis of psychotic disorder was made more frequently for the white group than for the nonwhite. For the white group, 25 percent (79) of the men and 13 percent (117) of the women were diagnosed as psychotic, while for the nonwhites ten percent (two) of the men and ten percent (14) of the women received a diagnosis of psychotic disorder. The other psychiatric diagnoses given to the nonwhite and white women were similar; however, nonwhite men received proportionately more diagnoses of neurosis or were more often classified as "other" than white men.

Table 6 presents the relationship of psychiatric care received by the suicide attempters to race and sex. Looking at this factor in terms of race, among 30 percent (353) of whites the suicide attempt represented the sole psychiatric contact, while this was so for 52 percent (82) of the nonwhites. And although 62 percent (738) of the white patients received care at some time after their attempt, only 43 percent (69) of the nonwhites received care subsequently. The differences in total psychiatric care were also striking when the white and nonwhite groups were examined by sex. For the men in our sample, 78 percent (252) of the white group, compared with 50 percent (11) of the nonwhites, had received some psychiatric care either before or after the attempt was made; all of the nonwhite men and all but 22 of the white men received care after the attempt. Among women, 67 percent (581) of the whites and 49 percent (66) of the nonwhites had received some psychiatric care either before or after the suicide attempt; for all but eight percent (73) of the whites and six percent (eight) of the nonwhites, care was received after the attempt.

As shown in table 7, three percent (35) of those who attempted suicide from 1964 through 1967 had died by the end of 1968; 51 percent (18) were women. All of the deaths in the nonwhite group were among those aged 25 to 44. In the white group, 52 percent (16) were men and 48 percent (15) were women. Ten of the deaths were attributed to suicide. In fact, suicide was the largest single cause of death in the sample and yielded a crude rate for those who attempted suicide of 595 per 100,000 per year. This is 57 times higher than the rate of 10.4 per 100,000

TABLE 6
Suicide Attempts by Psychiatric Care Received, Race, and Sex

Psychiatric Care Received	White				Nonwhite				Total	
	Male		Female		Male		Female			
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
For suicide attempt only	71	22	282	33	11	50	71	52	435	32
After suicide attempt	104	32	241	28	6	27	35	26	386	29
Before suicide attempt	22	7	73	8	0	0	8	6	103	8
Before and after suicide attempt	126	39	267	31	5	23	23	17	421	31
Total	323		863		22		137		1,345	

TABLE 7
Deaths Among Suicide Attempters Through 1968

Age Group	White		Nonwhite		Total
	Male	Female	Male	Female	
Under 25	1	0	0	0	1
25–44	4	7	1	3	15
45–64	7	5	0	0	12
65 and over	4	3	0	0	7
Total	16	15	1	3	35

per year for suicides in the general population. Of the suicides, three were men and seven were women; eight occurred in persons aged 25 to 44 (two of the men and six of the women). Examination of the suicides by race revealed that no nonwhite deaths were attributed to suicide.

DISCUSSION

Many of the results of our investigation support the findings of previous research. The overall ratio of women to men (3:1), the age distribution, and the marital status of our sample of suicide attempters are all in general agreement with the findings of other studies that have been conducted on this subject (10).

In our sample, we found a suicide attempt rate of 57.30 per 100,000 per year and a ratio of attempted to completed suicides of 5.5:1. If we take into account estimates of the suicide attempts that were treated at other hospitals in Monroe County, we obtain a suicide attempt rate of 74.69 per 100,000 per year and a ratio of attempted to completed suicides of 7.2:1. Even these must be regarded as underestimates, for, as Mintz (5) and others have suggested, many suicide attempts are probably never reported or treated in hospitals.

The overrepresentation of the lower socioeconomic levels in our sample, among both whites and nonwhites, lends support to the finding that the emergency services of general hospitals tend to be used more by the lower classes (11). This overrepresentation suggests: 1) that the suicide attempt rate is higher for people in the lower socioeconomic levels, 2) that they are treated for a wider range of self-destructive behavior than people in other classes, or 3) that people from the upper and middle socioeconomic levels may be treated for suicide attempts in places other than emergency departments of general hospitals, e.g., a private physician's office.

Ninety-two percent of our sample received a psychiatric diagnosis at the time of the suicide attempt; however, relatively few were diagnosed as having a psychotic disorder. For many, the suicide attempt appeared to be only one aspect of more general psychopathology, for some it appeared to have contributed to their receiving psychiatric treatment in the future, and for others it appeared to be the result of a single stressful or disorganized period.

Our study also points out major differences between whites and nonwhites who attempt suicide. Although Hendin (12) has suggested that the rate of completed suicide is higher for younger nonwhites than it is for whites and some suggestions have been made in the literature concerning the higher suicide attempt rates for nonwhites, relatively little has been done in the past to systematically examine racial differences. The data from this investigation suggest that white and nonwhite groups who attempt suicide are two distinct populations that may require different predictive, intervention, and treatment methods. The rate of attempts by nonwhites was 160 per 100,000 per year, compared with 53 per 100,000 per year for whites. The ratio of women to men for nonwhites was 6:1, in contrast to the ratio of 3:1 for whites. The nonwhite group was also younger and more often came from the lower socioeconomic levels. Marital status also separated the whites from the nonwhites. Although the majority of attempts in both groups were made by married or single persons, nearly a third of the nonwhite women were either separated, divorced, or widowed and more than half of the nonwhite men were single. In addition, fewer nonwhites had received psychiatric care either before or after the suicide attempt and nonwhites were less often diagnosed as having a psychotic disorder than whites.

These results could be interpreted as reflecting a lesser degree of psychological disturbance in the nonwhite population, as well as a difference in motives and dynamics between the whites and nonwhites who attempt suicide. However, the data could also be interpreted as reflecting different patterns of care or access to treatment for the nonwhite and the white groups. The lower proportion of nonwhites who received care before and after the attempt could be the result of the availability of fewer facilities to nonwhites or of the reluctance of nonwhites to use existing psychological services or to follow through with referrals. The data could also reflect different diagnostic biases on the part of mental health professionals, or even a "screening-out" process that may selectively exclude nonwhites from treatment. Further research is needed to determine which factors or combinations of factors are involved in these observed differences in diagnosis and patterns of care between the white and nonwhite groups.

There was also a noticeable difference between white and nonwhite groups in the incidence of completed suicide. The high risk for suicide in the suicide attempt group is most impressive among whites. Also of interest is the relatively young age at which the suicides occurred and the relatively short time span between the suicide attempt and the successful suicide. Although nonwhites accounted for 11 percent of the total number of deaths, none was due to suicide, while 32 percent of the white deaths were. This result is somewhat surprising since, for the total county population, nonwhites have a suicide rate of 8.98 per 100,000 per year while the rate for whites is 10.51 per 100,000 per year. Since nonwhites who commit suicide do not as often have a history of attempts, the attempts may not be as predictive of future suicides as they are for whites. For whites, the suicide rate among those

who had previously attempted suicide was much higher than that for whites in the general population. The rates for completed suicide among white suicide attempters were 743 per 100,000 per year for white men and 649 per 100,000 per year for white women, yielding an overall crude rate of 675 per 100,000 per year. This contrasts with an overall rate of 10.51 per 100,000 per year for suicides by the white population of the county as a whole. These findings suggest that among whites the likelihood that a person will commit suicide after an attempt is nearly 64 times as great as for someone in the general population. For nonwhites, however, suicide attempts appear to be negatively related to further self-destructive behavior. These results tend to support the conclusion that the nature of the suicide attempts of whites and nonwhites form two distinct patterns and should not be looked upon or investigated as a common problem with similar motives or prognoses.

This study indicates that people who attempt suicide can be differentiated by race in terms of demographic characteristics, diagnosis, psychiatric history, and the incidence of subsequent successful suicide. It further points out that even though relatively few nonwhites may be treated for suicide attempts compared with whites, the rates of suicide attempts in the nonwhite population are much higher. When treating people for suicide attempts, the physician may note differences between whites and nonwhites in the motivation for the attempt, the treatment techniques that are required, and the degree of risk for further psychiatric difficulty and/or suicide. It is vital that professionals working in the emergency services of general hospitals who deal with people from the lower socioeconomic classes, as well as with proportionately greater numbers of nonwhites than whites, be aware of these differences. In future research on suicide attempts, it would seem imperative to consider race as a separate factor. Not only are there clear differences between the groups but, when the groups are considered together, little information about the nonwhites is uncovered, since there is a relatively large ratio of white to nonwhite suicide attempters in most communities.

REFERENCES

1. Farberow N: Bibliography on Suicide and Suicide Prevention, Public Health Service Publication 1979. Washington, DC, US Government Printing Office, 1969
2. Stengel E: Suicide and Attempted Suicide. Baltimore, Penguin Press, 1969
3. Tuckman J, Youngman N: Identifying suicide risk groups among attempted suicides. Public Health Reports 78:763–766, 1963
4. Bogard H: Follow-up study of suicidal patients seen in emergency room consultation. Am J Psychiatry 126:1017–1020, 1970
5. Mintz R: Prevalence of persons in the city of Los Angeles who have attempted suicide: a pilot study. Bulletin of Suicidology, Fall 1970, pp 9–16
6. Tuckman J, Youngman N, Bleiberg B: Attempted suicide by adults. Public Health Reports 77:605–614, 1962
7. Farberow N, Shneidman E (eds): The Cry for Help. New York, McGraw-Hill, 1961
8. Gardner E, Miles H, Iker H, et al: A cumulative register of psychiatric services in a community. Am J Public Health 53:1269–1277, 1963
9. Babigian H, Odoroff C: The mortality experience of a population with psychiatric illness. Am J Psychiatry 126:470–480, 1969
10. Davis F: The relationship between suicide and attempted suicide: a review of the literature. Psychiatr Q 41:752–765, 1967
11. Jacobs A, Gavett J, Wersinger R: Emergency department utilization in an urban community. JAMA 216:307–312, 1971
12. Hendin H: Black Suicide. New York, Basic Books, 1969

A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients

BY SHELDON H. KARDENER, M.D., MARIELLE FULLER, AND IVAN N. MENSH, PH.D.

An anonymous questionnaire survey of a random sample of 460 physicians revealed that most psychiatrists, obstetrician-gynecologists, surgeons, internists, and general practitioners did not believe in the efficacy of or engage in nonerotic physical contact with their patients. Five to 13 percent of the respondents indicated that they engaged in erotic behavior with patients and five to 7.2 percent engaged in sexual intercourse specifically. The authors point out the need for greater openness and acceptance of discussion about and research in this highly sensitive and vital area.

THE HIPPOCRATIC OATH'S inclusion of an injunction against seducing one's patients clearly delineates this as an age-old concern of physicians. In practicing the art of medicine, doctors have been ethically obliged to judiciously distinguish between transmitting care, comfort, and reassurance in the "laying on of hands" or else transgressing into nontherapeutic or antitherapeutic practices. A combination of factors, including long-standing cultural taboos regarding the discussion of sexual matters, a need to maintain the idealized image of the physician growing out of a priest-practitioner heritage, and rampant ignorance due to a lack of adequate research, have contributed to the maintenance of mythology in all matters sexual. Where there is no fact, fantasy and fallacy flourish.

The historic (1) initial efforts by Ellis, Krafft-Ebing, Freud, Van de Velde, Kinsey, and, currently, Masters and Johnson have attempted to dispel ignorance by providing knowledge that prepares the physician to be of help to his patient. But is the physician, who is subject to the same cultural forces of sexual repression as his patient, prepared to be of help? In order to meet this challenge an increasing number of medical schools in the United States have instituted courses of instruction in the management of sexual disorders (2, 3). With this heightened focus of attention, there logically follows a recrudescence of old concerns regarding the role of the physician himself in relation to his patient.

Reactions to therapists who advocate sexual intimacy as therapeutic (4, 5) have been swift, strenuous, and condemnatory. Others (6–10) have written urging that while such responses may be appropriate, they should be the outgrowth not of blind reaction but rather of serious considerations and open-minded contemplations of the ethical, moral, and therapeutic issues involved, which allow for honest exploration of the question of sexual relations between physician and patient. They point out that guidelines for conduct are blurred and uncertain, as demonstrated by the introduction of each new therapeutic maneuver, i.e., nude marathons, "feeling" therapy, encounter groups, and emergence of a new morality. Further, these authors acknowledge the absence of and need for open discussion, critical appraisal, accumulation of a data base, and honest attempts to develop measures of therapeutic effectiveness.

It is within this spirit of scientific inquisitiveness, which acknowledges both the emotional sensitivity of the subject matter and the absence of existing data, that a pilot study was initiated to determine attitudes and practices of physicians regarding the use of nonerotic and erotic contact with patients.

METHOD

A 32-item, one-page questionnaire was designed that inquired about the respondents' age, years in practice, marital status, and the extent to which they attempted to treat sexual problems in their practice. Six questions followed that asked about their beliefs and practices regarding nonerotic contact with patients. Similarly, seven questions inquired about erotic contact with patients. Respondents were then asked to specify the actual number of patients involved in erotic contact excluding and including sexual intercourse. A final space allowed for other comments. Erotic behavior was specifically defined as that behavior which is primarily intended to arouse or satisfy sexual desire. Most of the questions, except for subjective and demographic ones, were to be answered by circling "0" (never), "1" (rarely—defined as less than five percent of professional experience or opinion), "2" (occasionally—less than 25 percent), "3" (frequently—more than 50 percent), or "4" (always). Two questions required replies specifying the actual number of patients with whom the respondent had had erotic contact.

The authors are with the Department of Psychiatry, School of Medicine, University of California at Los Angeles, Center for the Health Sciences, Los Angeles, Calif. 90024, where Dr. Kardener is Adjunct Associate Professor, Ms. Fuller is Research Associate, and Dr. Mensh is Professor of Medical Psychology.

Computer assistance for this work was obtained from the Health Sciences Computing Facility at UCLA, which is funded by Public Health Service grant RR-3 from the Division of Research Resources, National Institutes of Health.

TABLE 1
Responses to the Question "Do You Attempt to Treat Sexual Problems in Your Medical Practice?" by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
Total	445	11	27	36	26
P	109	3	3	30	64
OBG	78	1	23	49	27
S	68	50	35	9	6
IM	89	3	45	47	5
GP	101	7	34	42	18

A total of 1,000 male physicians were selected by random sampling from the membership list of the local county medical society (N=approximately 10,000). The study sample represented the five specialty groups of psychiatry (P), obstetrics-gynecology (OBG), surgery (S), internal medicine (IM), and general practice (GP), with 200 physicians in each group. The questionnaires identified only the respondents' specialty and were otherwise totally anonymous. Each was mailed with an explanatory cover letter and a stamped, addressed return envelope. The physicians' responses were tallied and the data studied by contingency table analysis (Biomedical Program BMD02S). Chi-square tests were used to determine significant differences between the groups thus analyzed.

RESULTS

General Data

Forty-six percent of the physicians responded (N=460). Four questionnaires were defaced with derogatory or profane comments. There were three letters of complaint that objected to the study and alluded to a (never specified) number of additional physicians who were offended. The questionnaire was sent only to male physicians and did not distinguish between homosexual and heterosexual relationships, since the study concerned itself with attitudes toward eroticism generally. In order to preserve anonymity, the only identifying characteristic known to the investigators was specialty. Therefore this is the only information available regarding nonrespondents.

By specialty, 25 percent of the respondents represented psychiatry (N=114); 23 percent, general practice (N=105); 19 percent, internal medicine (N=89); 18 percent, obstetrics-gynecology (N=83); and 15 percent, surgery (N=69). Chi-square tests indicated a significant difference among the five specialties' response rate ($p<.01$). Forty-two percent of the total respondents were 40 to 49 years old (N=194), and 33 percent were 50 to 59 years of age (N=151). Twenty-six percent reported being in practice for 11 to 15 years (N=117), 31 percent for 16 to 24 years (N=144), and 20 percent for 25 years or more (N=93). Eighty-six percent were married (N=393), three percent (N=14) single, eight percent (N=34) divorced or separated, and three percent (N=14) widowed. (Five respondents did not answer the question about marital status.)

There was a significant difference ($p<.05$) between the number of respondents who reported no prior marriages (81 percent, N=221) and those with one or more prior marriages (19 percent, N=51). The frequency distribution of those with no prior marriages was as follows: surgeons, 96 percent (N=44), obstetrician-gynecologists, 85 percent (N=39), internists, 81 percent (N=46), psychiatrists, 75 percent (N=46), and general practitioners, 74 percent (N=46).

In response to the question "Do you attempt to treat sexual problems in your medical practice?" the five groups responded in significantly different ways ($p<.01$) (table 1). This was due primarily to the differences between psychiatrists and obstetrician-gynecologists as compared to surgeons.

Nonerotic Behavior

Table 2 presents the data obtained in response to two questions regarding nonerotic behavior. Psychiatrists and obstetrician-gynecologists were significantly different in their beliefs, as compared to their internist and general practitioner colleagues ($p<.01$). Practice paralleled beliefs regarding nonerotic behavior with patients, again distinguishing psychiatrists, obstetrician-gynecologists, and surgeons from internists and general practitioners ($p<.05$). The response to questions regarding who initiates such practice indicated that, if it is the doctor, he will most likely be an internist or general practitioner ($p<.01$). Except for the nine percent (N=38) of the physicians who were frequently or always the initiator, all specialties reported that it was most often the patient who

TABLE 2
Responses to Two Questions Regarding Nonerotic Behavior with Patients, by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
"Do you believe nonerotic hugging, kissing, affectionate touching of patients may be beneficial to their treatment?"					
Total	447	32	30	28	10
P	112	30	43	25	3
OBG	81	40	32	16	12
S	65	39	25	26	11
IM	89	27	27	35	11
GP	100	28	22	37	13
"Do you engage in such practices?"					
Total	446	42	33	20	6
P	110	45	41	14	1
OBG	81	48	25	22	5
S	66	49	30	15	6
IM	89	32	34	24	11
GP	100	38	30	25	7

initiated the nonerotic contact, less often was it mutually initiated, and least often by the physician.

In response to the question "Do you believe such behavior would be misunderstood?" significant differences ($p<.05$) existed among the specialties ($N=430$). This was due primarily to the difference between psychiatrists, 69 percent ($N=94$) of whom believed that it would occasionally, frequently, or always be misunderstood, as compared with 40 percent ($N=66$) of the internists. The distribution of responses for the other specialties believing such behavior would occasionally, frequently, or always be misunderstood is as follows: obstetrician-gynecologists, 59 percent ($N=64$), general practitioners, 51 percent ($N=66$), and surgeons, 48 percent ($N=53$).

A subjective-response question asked under what circumstances nonerotic physical contact (holding, hugging, kissing) might be beneficial. Of the physicians responding, 74 percent ($N=184$) recognized the value of such behavior, particularly for providing comfort and in giving tangible support to a patient. The major specialty group explaining the value of this behavior were psychiatrists, 71 percent of whom ($N=53$) in previous responses (table 2) were shown to be least likely to believe in or to engage in nonerotic behavior with their patients.

TABLE 3

Responses to Three Questions Regarding Erotic Behavior with Patients, by Percentage

Category	N	Never	Rarely	Occasionally	Frequently or Always
"Do you believe erotic contact with a patient may be beneficial?"					
Total	450	80	15	3	1
P	112	80	17	3	0
OBG	81	83	16	1	0
S	66	74	12	11	3
IM	89	85	12	2	0
GP	102	78	17	2	3
"Do you engage in erotic practices?"					
Total	443	95	4	1	0
P	110	95	4	1	0
OBG	79	91	8	1	0
S	65	95	2	2	1
IM	88	95	5	0	0
GP	101	97	1	2	0
"Would this include sexual intercourse with a patient?"					
Total	358	95	4	0	1
P	85	95	5	0	0
OBG	70	94	4	0	1
S	49	94	4	0	2
IM	71	99	0	0	1
GP	83	93	5	1	1

Erotic Behavior

The data in table 3 indicate responses to several questions regarding erotic behavior with patients.

Erotic behavior other than intercourse tended to consist primarily of kissing; less often of manual or oral stimulation of the patient's genitals; rarely, such stimulation of the physician's genitals; and least of all, mutual genital stimulation.

To the open-ended question "Under what circumstances might erotic behavior be utilized in treatment?" 87 percent ($N=193$) of the respondents reported that it is never of benefit. Their statements included comments on ethical proscriptions, destructiveness to the doctor-patient relationship, dangerous loss of physicians' objectivity, injunctions in the Hippocratic oath, and comments that such behavior was "censurable," "unforgivable," and constituted "professional suicide" or was prima facie evidence of severe psychopathology in the physician. Explanations for the usefulness of erotic practices were offered by 13 percent ($N=28$) of the respondents and included such statements as "improves sexual maladjustments," "helps patients' recognition of their sexual status," "especially in the depressed, middle-aged female who feels undesirable," "for teaching sexual anatomy," "disclosing areas of sexual blocking," "for specific sexual problems [by being a normal partner]," "to demonstrate there is no physical cause for absence of libido," "to relieve frustration in a widow or divorcée who hasn't yet re-engaged in dating," "in mature patients flowing with nonconflicted [love] feelings," and "in healthy patients by mutual consent making the therapy go faster, deeper, and increases dreams."

There was significance ($p<.05$) between these two groups of responses. This was due to the proportionately larger number of surgeons ($N=6$) who favored the use of erotic behavior with patients as contrasted with general practitioners ($N=1$) so stating. In addition, ten psychiatrists, six obstetrician-gynecologists, and five internists gave responses favoring erotic behavior with patients.

A separate question asked for the actual number of patients involved with the physician in erotic behavior, specifically *excluding* intercourse. Of the responses, 89 percent ($N=277$) reported no such patient contact, while 11 percent ($N=33$) indicated affirmatively by specifying the number of patients so involved. Of those who responded affirmatively, 70 percent ($N=23$) reported that it occurred with fewer than five patients. Similar inquiry was made regarding the actual number of patients involved with the physician in erotic behavior, specifically *including* intercourse. Of these respondents, 89 percent ($N=263$) reported no such contact, while 11 percent ($N=33$) acknowledged such experiences. Of those who reported intercourse with patients, 79 percent ($N=26$) indicated that it involved fewer than five patients.

The four questions "Do you engage in erotic practices?" (table 3), "Would this include intercourse?" (table 3), "How many patients involved, excluding intercourse?" (table 4), and "How many patients including intercourse?" (table 4) served to delineate the incidence of erotic practices. A total of 59 physicians answered one or more of these four questions, while 33 respondents provided information for the last two questions. These data are presented in table 4. The distribution of responses was not statistically significant.

The results of these four questions would indicate that five to 13 percent of the total sample ($N=460$) engaged in

TABLE 4
Comparison of Erotic Behavior by Total Sample and by Specialty

Category	N	Any Kind of Erotic Behavior			Erotic Behavior Excluding Intercourse			Erotic Behavior Including Intercourse		
		Number of Respondents	Percentage of Specialty	Percentage of Total Sample	Number of Respondents	Percentage of Specialty	Percentage of Total Sample	Number of Respondents	Percentage of Specialty	Percentage of Total Sample
Total	460	59	—	12.8	33	—	7.2	33	—	7.2
P	114	12	10	2.6	6	5	1.3	6	5	1.3
OBG	83	15	18	3.3	9	11	2.0	6	7	1.3
S	69	7	10	1.5	5	7	1.1	5	7	1.1
IM	89	11	12	2.4	4	5	0.9	7	8	1.5
GP	105	14	13	3.0	9	9	2.0	9	9	2.0

some kind of erotic behavior with their patients (tables 3 and 4). Similarly, the incidence of erotic behavior, specifically including sexual intercourse, was five to 7.2 percent (tables 3 and 4).

A final space on the questionnaire provided for additional comments; it elicited 124 responses, which were sorted into eight categories. General comments, one of the eight categories, comprised 47 percent (N=58) of these responses and included discussions of the problems that would result from erotic behavior, questions about methodology, and an urging for more teaching in medical schools of sexual matters and for special seminars on this subject for practitioners. Four respondents (three percent) acknowledged that they knew "such things [erotic behavior] go on." Nine (seven percent) stated that sexual behavior should be kept out of the office. Twelve (ten percent) stated that erotic behavior was symptomatic of a doctor's illness. Nine (seven percent) indicated that they did not know if erotic behavior was beneficial or not. Fifteen (12 percent) felt that such behavior destroyed the doctor-patient relationship. Five (four percent) indicated great anger that this study was undertaken, i.e., "proves psychiatrists are nuts," "an insult to even be asked," "you're sick." In contrast, 12 of the respondents' comments (ten percent) were of a congratulatory nature applauding the effort and encouraging continued study.

DISCUSSION

The questionnaire afforded respondents a unique and anonymous opportunity for the expression of participation in unusual practices, and the data are therefore more likely to be representative of such practices. Each specialty represented tended to have its own slightly different orientation regarding engaging in the treatment of sexual problems and beliefs and practices regarding both erotic and nonerotic behavior with patients.

Psychiatrists and obstetrician-gynecologists reported a much higher frequency of the treatment of sexual disorders in their practices and were also more wary of nonerotic physical contact than their colleagues, since they primarily believed that such behavior would be misunderstood. At the same time, it was the psychiatrist who most often explained why such contact might be beneficial in the treatment of a patient. Internists and general practitioners, on the other hand, indicated a belief in and practice of beneficial, nonerotic physical contact with their patients. While surgeons differed sharply from the other respondents in overall response rate and frequency of treating sexual problems, they were, nonetheless, more allied with psychiatrists and obstetrician-gynecologists regarding beliefs and practices of nonerotic physical contact.

The questions regarding actually engaging in any erotic behavior with patients, and in sexual intercourse specifically, indicated a lower incidence (five percent) than did those questions asking for a specific number of patients involved in any erotic behavior (13 percent) and in sexual intercourse specifically (7.2 percent). Possible explanations for this variance include: 1) these questions differed from the others by requiring that a specific number be given and 2) they appeared later in the questionnaire, apart from the patient management considerations per se. Further, physicians participating in this kind of activity with patients do so because they feel they have both a professional and a separate social relationship with these patients. Several respondents specifically gave this explanation on their questionnaires.

It was in the area of belief—not practice—that erotic contact may be beneficial that the surgeons differed from the other respondents (table 3). They constituted 26 percent (N=17) of the total sample of 19 percent (N=88) of physicians who believed that such behavior might be beneficial. Twenty percent of the psychiatrists (N=22) held this view.

It may be worthwhile to compare these responses (19 percent) by physicians with those of medical students, since the latter group represents an earlier phase in the professional career. Wagner (11) reported that 25 percent of the freshmen medical students surveyed felt that sexual intercourse with a patient could be appropriate under the "right circumstances" if the doctor was "genuine" and "authentic." These figures delineate a core of both physicians-in-training and physicians-in-practice, separated by years of age and years of medical practice experience, who are seriously asking, "Why not?" It is a question deserving of an answer and represents an important

challenge to medical teachers engaged in sex education. A greater understanding of the emotional parallel between the doctor-patient and parent-child relationships may provide such an answer. Of particular interest in this regard is Woodbury and Schwartz's study of parent-child incest (12), which indicated an incidence similar to that of the doctor-patient erotic contact reported here.

REFERENCES

1. Brecher EM: The Sex Researchers. Boston, Little, Brown and Co, 1969
2. Romano J: Teaching medical students about population, sexual practices, and family planning. J Med Educ 43:898–906, 1968
3. Stenchever MA: Human Sexual Behavior: A Workbook in Reproductive Biology. Cleveland, Division of Research in Medical Education, School of Medicine, Case Western Reserve University, 1970
4. McCartney JL: Overt transference. Journal of Sex Research 2:227–237, 1966
5. Shepard M: The Love Treatment: Sexual Intimacy Between Patients and Psychotherapists. New York, Peter H Wyden, 1971
6. West LJ: Ethical psychiatry and biosocial humanism. Am J Psychiatry 126:226–230, 1969
7. Braceland FJ: Historical perspectives of the ethical practice of psychiatry. Am J Psychiatry 126:230–237, 1969
8. Branch CHH: Do ethical standards change? Am J Psychiatry 126: 244–245, 1969
9. Van Einde Boas C: Some reflections on sexual relations between physicians and patients. Journal of Sex Research 2:215–218, 1966
10. Dahlberg CC: Sexual contact between patient and therapist. Contemporary Psychoanalysis 6:107–124, Spring 1970
11. Wagner N: Ethical concerns of medical students, presented at the 1972 Western Workshop of the Center for the Study of Sex Education in Medicine, Santa Barbara, Calif
12. Woodbury JM, Schwartz E: The Silent Sin. New York, New American Library, 1971

Answers to Questions of the Month

Page 1070. Question 1:C; Question 2:E.

Psychiatry in Shanghai, China: Observations in 1973

BY DAVID N. RATNAVALE, M.D.

At the invitation of the Chinese Ministry of Health, the author visited China earlier this year. He describes the structure and organization of the Shanghai Psychiatric Institute, a therapeutic community in which the staff and patients work together in a classless social organization, which is part of a medical system that blends the modern and the ancient traditional medical practices. The author presents brief general information on acupuncture and describes its use in psychiatry, but stresses the preeminence of group activities in the therapy of mental illness.

THE CLINICAL MANAGEMENT and care provided to persons suffering from psychiatric illness cannot be described in isolation from the cultural, social, economic, and political milieu from which they spring. Hence, the interpretation of modern trends in a land as ancient and as immense as China is no ordinary task. The problem is further compounded by our scientific requirement of perceiving change through Chinese senses while maintaining an objective investigatory posture.

The people of China, when faced with psychological issues, are reputed to have ready mental access to a vast compendium of "old Chinese sayings." This may simply give them time to ponder before reacting, but it reveals plainly their reverence for the ancient and their readiness to connect the past and the present.

We are now seeing the consequence of Chairman Mao Tse-tung's call during the Great Leap Forward in 1958: "Chinese medicine and pharmacology are a great treasure house. Efforts should be made to explore them and raise them to a higher standard." He has given impetus to the study of ancient Chinese medicine and modern medical science contemporaneously; through the vigorous pursuit of this national policy he has substantially reoriented the entire system of medical practice and teaching in China. Psychiatrists and mental health workers in China tell us that the developments in their psychiatric services parallel the growth observable in all other spheres of human activity and thought since the "liberation" of 1949.

I was invited by the Ministry of Health and the staff of the Shanghai Psychiatric Institute to study current psychiatric practice in China and to share my research experience in Sri Lanka (formerly Ceylon), where I had investigated the difficulties inherent in any attempt to blend the ancient indigenous (ayurvedic) medical system with Western medicine. This paper presents a description of a hospital in Shanghai, one of the world's largest cities, in the Kiangsu Province of the People's Republic of China. I shall attempt to identify modern trends in psychiatry and the therapeutic modalities in use. Special attention will be paid to acupuncture in psychiatry and therapeutic group processes.

At the time this paper was written, Dr. Ratnavale was a senior psychotherapist at Chestnut Lodge, Rockville, Md. He is now Associate Professor of Psychiatry, Eastern Virginia Medical School, 721 Fairfax Ave., Norfolk, Va. 23507.

SHANGHAI PSYCHIATRIC INSTITUTE

The Shanghai Psychiatric Institute, constructed in 1958, is a large complex of modern concrete buildings situated in a surburban section of Shanghai. The 1,000-bed hospital and the specialized departments that serve it cover half the total area of the premises (40,000 square meters), which itself is enclosed by a cinnamon-colored wall three meters high. Directly across the road—Chin Chi Road—lies the impressive Lon Hwa General and Teaching Hospital.

As one enters the imposing gates of the Shanghai Psychiatric Institute, one's gaze is met by a tall rectangular slab of cement bearing a quotation of Chairman Mao Tse-tung about freedom. The buildings of the institute surround a spacious garden-like courtyard where patients are seen at play; it is tastefully landscaped with flowering and evergreen trees.

The hospital is divided into 13 airy and plainly furnished units with rooms that sleep eight to 16 patients. The patients have the responsibility for maintaining their quarters but are assisted in this function by the nurses and health workers. There are a few single rooms but these are rarely used, since the isolation of patients is strongly discouraged. On one wall of every unit is painted an appropriate quotation from Chairman Mao, e.g., "Help one another; care for one other; love one another."

The Psychiatric Institute is served by a staff of 556 persons. Fifteen administrators, four of whom are psychiatrists, under the chairman of the revolutionary committee of the hospital, are responsible for managing the institution. Dr. Yen Ho-Chun, a psychiatrist, is the medical director. His assistant, Dr. Shu Sun-Ha, is also the vice-chairman and has just completed two years of specialized instruction at a famous center for Chinese traditional medicine. Of the 61 psychiatrists, 11 are women. All have received training in both modern Western medicine and traditional Chinese medicine.

At any given time as many as a third of the staff psychiatrists are away in rural areas serving with other specialists on mobile medical teams for as long as six to 12 months. There they are engaged in treating patients, instructing commune and barefoot doctors (*chú chiao*—"a peasant who has had basic medical training and gives treatment without leaving productive work" [1]), and disseminating information on mental health. Their rural encounter is also considered to be a learning experience.

A distinctive feature of the working staff of the hospital, which includes 218 nurses, is the absence of any insignia of rank. Indeed, my overall impression was that staff members were under less stress than their fellows in other lands and I was struck by the ease of conversation among professional, paraprofessional, and patient.

The Shanghai Psychiatric Institute and similar institutions provide treatment facilities for the whole society; it is asserted that, in the preliberation period when adequate health care was available only to the privileged classes, "hospitals did not satisfy the needs of the people." The patients are now receiving the benefits of both the traditional Chinese and the modern Western medical systems and treatment is provided for all types of mental illness. The outpatient clinic is reported to receive as many as 400 patients a day, the majority suffering from neurotic and psychosomatic conditions. A small percentage of patients with epilepsy are also seen for checkups or renewal of medication. On the average, hospitalization lasts for ten to 12 weeks and families generally visit patients twice a week. There is no charge for therapy, but a small payment is sometimes levied for food.

There is no separate staff category that corresponds to our social workers. The functions of social work are absorbed by the working staff, who maintain steady contact with families and with members of the patients' working units. Every patient is certain that his job will be waiting for him when he returns to work.

The inpatients range in age from 20 to 35. The incidence of psychiatric disorders below the age of 15 is said to be very low. Indeed, the absence of aged, regressed, or agitated patients is also striking. Over half the patient population suffers illness of psychotic proportions, chiefly schizophrenic syndromes. The psychiatrists are unanimous in their claim that the incidence of depressive syndromes (*yu yiu-tsen*), postpartum psychosis, and suicide is significantly low. They also note the rarity of senile psychoses—an observation recorded by Tsung-Yi Lin in another Chinese community (2).

They also asserted that chronic alcoholism, opiate addiction, and drug abuse in general had been eliminated, and I concur with the group of American physicians who visited China in 1971 that "not a single instance of drunkenness was observed day or night in our travels in the cities and countryside" (3). Our Chinese colleagues attribute their success partly to widespread educational campaigns and partly to the efficient halting of illicit production. Lowinger (4) considered "the changed ideology of the young people . . . the changes in outlook, which included a redefinition of the nation and its youth, of their worth and role" to be a major force. Indeed, the eradication of the poppy fields in a land that is 80 percent "countryside" and the recultivation of these fields with food crops indicates the size of the task and the efficiency of the programs.

The newer developments within the Shanghai Psychiatric Institute are identified with parallel changes in the nation as a whole; they indicate that a shift in the attitude toward mental patients and their care followed in the wake of the "great proletarian revolution" under Chairman Mao's leadership. He is quoted frequently as a source of guidance and inspiration and his sayings are conspicuously displayed in all public places. He is seen as a true advocate of the classless society, in which all hospital workers and all patients belong to one socioeconomic category, and all remember his exhortation to approach patients "with wholeheartedness," "paying attention to environment and past beliefs." He sponsored the revival of ancient and traditional medicine (including acupuncture) and the establishment of equal status for modern Western-oriented physicians (*si-i*), barefoot doctors (*chú-chiao*), and traditional healers (*zjung-i*).

The physicians and health workers at the Psychiatric Institute emphasized the point that, in line with the concept of a people's republic, the hospital is perceived as a people's hospital, and they were generally inclined to view each ward or hospital unit as a family.

TREATMENT: METHODS AND PHILOSOPHY

The preeminent therapeutic emphasis appears to be related to the reestablishment of a "sense of group" or "sense of belonging." The group therapeutic activities include ideological education, play, singing, reading, and "heart-to-heart talks." One can add "group acupuncture" to this list since acupuncture is now administered to more than one patient simultaneously. Chemotherapy, herbal medicine, and acupuncture comprise the nonpsychological approaches. Electroconvulsive therapy and insulin shock treatment have been discontinued.

Chemotherapy

The standard Western psychopharmacological products (e.g., tricyclic antidepressants and phenothiazines) are used, along with herbal preparations. In general, the dosages are smaller than those prescribed in the West; 250 mg. of chlorpromazine per day is considered to be a high dose. It is suggested that the concurrent administration of herbal medicines reduces the need for higher dosages. The Psychiatric Institute maintains a large herb pharmacy that dispenses pills and decoctions manufactured from medicinal roots, bark, and leaves.

Acupuncture

Acupuncture appeared in Central Asia as early as the Neolithic period and its application has been passed down to us through a few records. An extensive exposition is found in the *Huang-ti Nei Ching Su Wen* [*The*

Yellow Emperor's Classic of Internal Medicine] (5), whose composition is placed by some authorities at 2697 B.C. and by others at the third to fifth century B.C. (6). A textbook, it takes the form of a dialogue or "familiar conversations" between Huang-ti the Emperor and his minister-physician Ch'i Po. Students of Chinese medicine look to the *Nei Ching* not only to read medical history, but also to understand its development and current usage.

Acupuncture consists of the insertion of needles into particular points on the body that lie along 12 channels or *ching* (*ching lo* theory). These *ching* are said to be deeply set and not in direct communication with the blood vessels but to emerge to the surface at 365 or more places, presenting the points for needling. The anatomical locations of these *ching* have yet to be defined. Acupuncture, which is widely practiced in China, involves an understanding of the principles of *yin* and *yang*, maintaining a balance between *ch'i* (air) and *shiueh* (blood), and "needling," which establishes equilibrium by removing stagnation and neutralizing excesses.

The use of acupuncture in psychiatry and anesthesia is of relatively recent origin. Though its use in psychiatry has not been adequately reported in the literature, despite its regular use in Chinese mental hospitals, acupuncture anesthesia has won considerable publicity and is extensively employed in China (by conservative estimate it has been used in more than 400,000 operations since 1968) with a 90 percent reported success rate.

The Melzack-Wall hypothesis (7) offered some hope of a neurophysiological explanation for acupuncture anesthesia, but the answer remains unsettled. This hypothesis holds that perception of pain involves a "gate control" system, primarily located in the substantia gelatinosa of the spinal cord, and that effective closure of this "gate" blocks pain from reaching the higher centers. Man and Chen (8) postulated that there is a second gate in the thalamus, while others have summarily dismissed the phenomenon as something that makes "no sense anatomically" or that it is due simply to the effect of distraction and hysteria. Even serious students have been vocal about the "power of suggestion," but they are hard pressed to explain what they mean. Cooperative exploration by psychologists, psychiatrists, and neurophysiologists is surely called for. Huard and Wong (6), reporting on acupuncture in psychiatry, noted that "in psychiatry the effect of acupuncture is nonexistent, and hysterical and coxalgic patients have been seen to resist the needles but not the electric shock" (p. 215). Sidel (9) has reported the use of acupuncture in treating schizophrenia, excitement, catatonia, and depression.

I observed the administration of acupuncture to patients individually and in groups at the Shanghai Psychiatric Institute, where acupuncture has been in use since 1966 and is now standard treatment. Psychotic and neurotic patients are given acupuncture along with other types of treatment. It is considered particularly helpful in treating syndromes characterized by excitement, anxiety, apathy, catatonic stupor, and depression. Points on the limbs and trunk have been identified for needling in psychiatric conditions; they lie along the standard *ching*, but why these points have been selected over others has still to be explained. Future research must satisfy this question and also establish the specific value of this form of treatment.

Eleven points reported to be specific for psychiatric illness are: *ho ku*, a *yang ching* on the extensor aspect of the hand in the muscle belly of the first dorsal interosseous muscle; *nei kuan*, a point on the flexor aspect of the forearm one inch from the wrist crease; *lau kong*, in the center of the palm; *shiao shang*, a *ying ching* on the outer aspect of the nail bed of the thumb; *tsu san li*, a point one inch below and behind the head of the fibula; *tai shung*, on a line between the first and second toe, two fingerbreadths above the web; *yung chuwan*, on the sole of the foot at the junction of the anterior and middle third; *yi fong*, on the posterior aspect of the ear lobe; *tin kong*, immediately anterior to the tragus of the ear; *bei wei*, on the center of the scalp; and *tai yang*, at the temple.

During acupuncture the patient usually complains of a mild local "soreness," "distension," or "tightness." Manual twirling of the needle is still practiced but more commonly a current of four to six volts is passed to the implanted needle via a portable regulator box no bigger than a small transistor radio. The box, with several terminals, allows for treating more than one patient (as many as six) at a time and requires only one therapist. Each treatment lasts 20 to 30 minutes and is administered twice daily, daily, or three times a week. A positive response (essentially the reduction of symptoms) is usually noticed after two weeks of treatment, but the course generally lasts from five to six weeks. If no improvement is noted in three weeks the method is discontinued.

The doctors at the Shanghai Psychiatric Institute implied that acupuncture has replaced ECT in their hospitals but they do not, at this stage, venture any definite explanation of its action. They list its advantages over ECT and note primarily its safety, simplicity, and availability and the absence of such side effects as memory impairment. It must be emphasized that doctors and scientists in China make no pretense of fully understanding the action and effect of acupuncture and that active research is going on in this area.

Therapeutic Group Processes

Group play at the Shanghai Psychiatric Institute chiefly involves uncomplicated noncompetitive games. Groups of patients are seen lobbing a basketball to one another in a game that resembles "catch." Another game consists of tossing a rubber ball or shuttlecock to a partner with a wooden paddle. In table tennis, however, a little of the competitive spirit is evidenced.

In group singing patients and nurses stand around a pianist and violin player and sing animated folk songs or songs of victory that have a somewhat martial flavor and that deal with liberation and freedom.

In group reading patients or health workers take turns reading simple literary works, news reports, or children's books.

"Heart-to-heart talks" amount to informal chats in small groups or individually with a psychiatrist or nurse.

Ideological Education

By far the most emphasized therapeutic group activity is ideological education. It is given to all patients at some period of their hospital life. A newly admitted acutely disturbed or confused patient does not participate in this mental exercise until the ward psychiatrist, nurse-instructor, and patient group acknowledge his ability to become involved.

This method is aimed at "mobilizing the patient's initiative" through discussions, questions, and the examination of such famous works as the teachings of Chairman Mao. The subject matter is concerned with objectivity, freedom, openness, equality, and caring for one another and represents the basic material for ideological education. Learning and discussing the teachings of Chairman Mao, it should be noted, is a popular and serious activity in all spheres of life in China; reading, studying, and debating his works is considered to be a highly salutary pursuit. It is understandable that this would be a part of hospital life.

In these sessions, asking questions and repeating them until they are satisfactorily clarified is greatly encouraged. There are thus no "stupid questions," only comrades who cannot adequately explain their answers. For example, a group may be engaged in the study of Mao Tse-tung's writing on "Where do correct ideas come from?" or "Can bad things be turned into good things?" This would be the basic material for exploring the ideas and feelings of the patients. In one such discussion, the nurse-instructor (the group leader) expressed the view that, in interacting with patients, a group leader "must not be critical, but instead willing to explore the conflict that led to the patient's puzzlement or false ideas; that an atmosphere of trust must be created and engendered; that investigations and explorations should be wholehearted and intensive."

Case Report

The following report was related to me by a psychiatrist at the Shanghai Psychiatric Institute[1]:

A woman nearing the age of 50 (the usual retirement age) was informed by her working unit that she was going to be retired. She had a "false thought" that she was being expelled and wondered whether she was to be dismissed because her ability and performance were poorer than those of the other workers. She got the idea that if she worked hard she might be offered the opportunity of working two shifts instead of one. She was, of course, actually ill. In addition, she had insomnia and loss of appetite. At the institute her treatment consisted of chemotherapy, acupuncture, and group activities.

In her group, she was urged to compare the past and the present, the time before liberation and the present time. She was reminded that in the past the old workers, the aged workers, were "kicked out by the capitalists" and that it was very difficult for them to obtain any pension or other support. Her "actual" current situation and the new labor regulations that provide certain guarantees were explained to her. She was helped to recognize that there was glory in the work she had already done and that she could retire with the feeling that her career was one that brought glory to herself and to her country. She was helped to see that her thoughts were distorted and therefore wrong. She enjoyed and benefited greatly from her group experience.

Follow-up of her case was carried out at the outpatient clinic; weeks after her discharge the unit wrote to her and she replied with news of her improved state. In cases of this kind, the "visiting team" would go to the patient's home or working place to check on her progress and to help "consolidate the efficiency" of her improved state. Her treatment was therefore a combination of chemotherapy, acupuncture, and group therapy. Follow-up aided in consolidating her gains and facilitating the development of a new relationship between her and her fellow workers.

We are frequently disappointed when our theoretical conceptualizations fail to explain the action or results of techniques unfamiliar to us. The language is the same but the dialects are different, a situation that creates no less misunderstanding than has existed between so-called organicists and those considered psychodynamically oriented.

How are we to understand the clinical example cited or the statement that "ideological education is offered in a way that helps to integrate and reorganize a patient's thinking"? Is it enough to accept therapeutic efficacy simply in terms of realigning illogical thought through a dialectic process (defined as the art or practice of examining opinions or ideas logically, often by a method of question and answer so as to determine their validity), or can we safely assume that other psychological events are taking place concurrently?

We are faced with the task of translating traditional Western concepts concerned with such things as the mother-child relationship, ego development, psychosexual phases, psychic trauma, and transference to the state of affairs that prevails in China and of opening our minds to new ideas. In such a pursuit it would be wise to guard against too hasty a presumption that our Chinese colleagues organize these concepts along similar lines but within a framework that we do not as yet understand. They are willing to share their clinical experience and for this privilege we are obliged to study *with them* the intricacies of the methods they employ. We are called upon to face simple questions related to causation and curability. In a field that has no universal criteria for cure, we must at least be content to accept as a primary consideration a patient's capacity to return to his work and his home life.

If we begin to scrutinize one of the primary psychological therapies practiced at the Shanghai Psychiatric Institute, with an inclination to view it as a form of group therapy, it would be perfectly valid to ask why it receives their main emphasis, what makes it an effective modality, and how it works.

In the West, and especially in the United States, group therapy as a psychotherapeutic method has almost lost the stamp of science. Its exponents vary from psycho-

[1] When I asked whether this patient's case would fit in the category of depressive illness, I was informed that she had received a diagnosis of "involutional melancholia."

analysts to nudists, and it has come to mean (in the public eye) any type of group activity that ameliorates psychic tensions and that facilitates improved interpersonal relationships. Regrettably, there is little consensus regarding the indications for group therapy, although there is general agreement that people who are deprived of adequate group experiences or who are unduly uncomfortable in groups can benefit from such treatment. We also know that cultural and social factors—one's concept of family life, of independence and autonomy, of intrafamily loves and jealousies—all influence attitudes toward one's self and one's fellows.

Reduced to its simplest meaning, group therapy aims at the evolution of a sense of group or the redevelopment of that sense, once known but abandoned. Within this simple context, it might be profitable to consider the meanings of "group sense" to a person in Chinese society today and its value and significance in group treatments in Chinese mental institutions.

The attitude of Westerners toward China has fluctuated considerably during recent centuries and has significantly influenced Western perceptions of the Chinese character. Anthropologists and social scientists speak of the Chinese need to "save face" and their "inscrutability." Western LaBarre (10), writing in 1946, noted that "the Chinese are not militaristic . . . not imperialistic . . . non-mercantile . . . and not essentially an urban people." Weakland (11), in "Orality in Chinese Conceptions of Male Genital Sexuality," discussed their "oral thinking." Hsein Rin (12) noted the marked emphasis on orality in the Chinese, giving as evidence "the frequent and prolonged breast feeding of babies and the prominent and almost exclusive role of mothers in bringing up children." Tsung-Yi Lin (2) observed that "the threshold of Chinese families in regard to abnormal behavior is rather high." Muensterberger (13), in a study of the character of the southern Chinese, wrote that "those who know report that, although the Chinese woman suffers under many restrictions, she plays a more influential role within her family than does the man."

In general, students of Sinitic studies agree that, however alien the surroundings, the fundamental and centrally organizing factor in Chinese social life is the family. That this appears to be true of modern China is hard to dispute, and a discussion of the persistence of this characteristic in the face of radical alterations in role functions and expectations in the present-day Chinese family group is a worthwhile project.

ASPECTS OF GROUP CONSCIOUSNESS

The meaning of the group may well be somehow different in China, but there is evidence to suggest that the group has a highly therapeutic meaning. Interpreting national policy and its influence upon Chinese society is beyond the scope of this paper, but reference must be made to current developments within the nation that appear to significantly enhance group consciousness throughout life. At least four intimately related areas deserve our close attention: 1) the reverence toward children in modern China, 2) the liberation of women, 3) a heightened awareness of the oppressed minorities, and 4) the popularity of "speaking bitterness." Inherent in these phenomena is a recollection of how things used to be and an affirmation of the positive changes that have been made.

Reverence for Children

Despite historical references to poverty-stricken eras when parents were driven to extremes, the Chinese love of children is taken for granted. This basic attitude is being augmented by present-day leadership. Mao Tse-tung has said: "The world is yours, as well as ours, but in the last analysis it is yours. You young people, full of vigor and vitality, are in the bloom of your life, like the sun at eight or nine in the morning. Our hope is placed on you. The world belongs to you. China's future belongs to you."

From very early in an infant's life, as early as 56 days old, he might be placed, like 90 percent of his peers, in the nursing room of the factory where his mother works. She will come to feed him at least twice each day, but during the rest of the working day he is in the care of several "aunties." These aunties, or auxiliary mothers, are selected from among the workers and chosen for their patience, warmth, and heightened sense of responsibility. Thus, quite early a mother begins to rely on other people to assist her in rearing her babies, and the child comes to recognize that he is a member of a group. Indeed, the children feed together, play together, and after breakfast sit on individual potties and have their bowel movements together.

News about new schools and about developments in education is widely disseminated. Under the title "More Nurseries and Kindergartens in Tienstin," the *Chinese Medical Journal* (14) reported: "In addition to singing and dancing lessons, the children learn to tend vegetable gardens and raise chickens and rabbits in order to inculcate in them the love of labor," and under the title "Better Health for Tibetans": "Nurseries and kindergartens are staffed, in the main, by young women who have received special training in child psychology, health protection, and nutrition. Research work is being conducted to improve the care and education of pre-school age children. Meetings of child care workers, for exchanging experiences, are held regularly."

Women's Liberation

It is generally believed that, until recently, women held an inferior position in China and were the voiceless, faceless, footbound servants of their masters, gaining a modicum of status only upon becoming mothers-in-law. New marriage laws, social changes, and raised expectations have altered their traditional postures so that now they kowtow to no one, enjoy equal rights, and receive equal pay for equal work. R. Sidel's observations (15) lend credence to these changes, noting also that basic attitudes toward motherhood remain stable.

Oppressed Groups of Past Days

It is well known that in bygone times peasants and minority nationalities, especially in remote regions, were at the mercy of warlords who plundered their produce and held them in fear and submission. These groups are now enjoying the limelight in a conscious, deliberate manner. The theater, opera, and radio consistently depict their earlier predicament and compare the past with the present. It would appear that the term "minority" is frequently equated with "underprivileged," in a way that expresses the earlier status of the peasant classes (who, though numerically in the majority, were the minority in a social and economic sense).

Speaking Bitterness

"Speaking bitterness" refers to a phenomenon that became very popular and was greatly encouraged after the liberation. Through "speak bitterness" meetings, an acceptable forum was created for people to describe their past hardships in a dramatically cathartic fashion. It served to purge one's impacted resentments and, through identificatory processes, the bitter feelings of their hearers as well. It served also to identify the present politicosocial system as one that rescues and nurtures, but apparently it did not stop there. Rather than foster a helpless dependency, the will of the individual and the group was bolstered into recognizing that only through their group consciousness, vigilance, and hard work could the present gains be protected and sustained.

Only four areas have been portrayed; presumably there are more. They have the quality of novelty and whet one's curiosity. Yet, they sound like old ideas or just ordinary sentiments. They seem to remind us that children have always been cherished—and needed it; that women invariably exerted profound psychological strengths—and needed to; that the oppressed and small at all times found an advocate; and, last but not least, that people have always complained.

I recognize the difficulties inherent in the interpretation of unfamiliar methods and ideas. I would caution against hasty generalizations and urge a deeper study of the topics discussed in this paper.

ACKNOWLEDGMENTS

I wish to thank my Chinese hosts, my colleagues at the Shanghai Psychiatric Clinic, and their patients for their trust and generosity. Without their help and the unhurried assistance of Dr. Yu Lu-yi and both Mr. Chiang and Mrs. Wu Sheu Cheng of Shanghai's Municipal Bureau of Public Health this work would not have been possible.

REFERENCES

1. Everybody works for good health. China Reconstructs 10(11):20–22, 1971
2. Lin T-Y: A study of the incidence of mental disorder in Chinese and other cultures. Psychiatry 16:313–336, 1953
3. Notes on drugs and therapeutics in the People's Republic of China. Med Lett Drugs Ther, Sept 1, 1972, pp 65–68
4. Lowinger P: How the Chinese solved their drug problem. Medical Opinion 2(3):81–92, 1973
5. Huang-ti Nei Ching Su Wen [The Yellow Emperor's Classic of Internal Medicine]. Translated by Veith I. Berkeley, University of California Press, 1966
6. Huard P, Wong M: Chinese Medicine. New York, World University Library, 1968
7. Melzack R, Wall PD: Pain mechanisms: a new theory. Science 150:971–979, 1965
8. Man PL, Chen CH: Acupuncture "anesthesia": a new theory and clinical study. Curr Ther Res 14:390–394, 1972
9. Sidel R: Medicine and Public Health in the People's Republic of China. Washington, DC, US Government Printing Office, 1972, p 295
10. LaBarre W: Some observations on character structure in the Orient, part 2. Psychiatry 9:375–395, 1946
11. Weakland JH: Orality in Chinese conceptions of male genital sexuality. Psychiatry 19:237–247, 1956
12. Rin H: A study of the aetiology of koro in respect to the Chinese concept of illness. Int J Soc Psychiatry 11:7–13, 1965
13. Muensterberger W: Orality and dependence: characteristics of Southern Chinese. Psychoanalysis and the Social Sciences 3:37–69, 1951
14. Notes. Chinese Medical Journal 82:64, 1963
15. Sidel R: Women and Child Care in the People's Republic of China. New York, Hill and Wang, 1972

Evolving Behavior in the Clinical and Experimental Amphetamine (Model) Psychosis

BY EVERETT H. ELLINWOOD, JR., M.D., ABRAHAM SUDILOVSKY, M.D., AND LINDA M. NELSON

A parallel is drawn between several behavioral constellations observed in the evolution of the human amphetamine psychosis and the motor-postural-attitudinal manifestations induced in animals by chronic amphetamine intoxication. On the basis of the results reported, a triple-layered model of psychosis is suggested and the roles played by participating neurotransmitters and mechanisms are further elaborated.

IN A CLINICAL SETTING, the amphetamine psychosis develops over a period of time as the user gradually increases his intake of amphetamine to amounts ranging from 150 to 2000 mg. per day. Although the paranoid psychotic state evolves gradually as a result of this chronic abuse, the patient is seldom seen by a physician until the process is far advanced. By this time he presents a fairly distinct syndrome, with delusions of persecution, ideas of reference, visual and auditory hallucinations, changes in body image, hyperactivity, agitation, and panic.

In previous studies we have asked whether there are behaviors that precede the last stage and may, in fact, be related to the development of the paranoid schizophrenic-like picture. More specifically, we have been interested in the anlagen of the behaviors that evolve over time since several of the antecedent behaviors we have observed in human chronic amphetamine abusers present fairly distinct constellations or clusters (1, 2).

One of these constellations involves an intense feeling of curiosity, often manifested by repetitious, stereotyped examining, searching, and sorting behaviors. This repetitious activity has been variously called "punding" (3), "hung-up activity" (4), "obsessive-compulsive tendencies" (1, 5), and "knick-knacking" (by inhabitants of the Haight-Ashbury scene). Its characteristic feature is engagement in tasks that primarily involve small bits or minutiae and a marked enhancement of perceptual acuity directed toward these minute objects. At times there are perceptuo-motor compulsions, manifested as repetitious stringing of beads or as acts of arranging, sorting, and lining up pebbles, rocks, or other small objects (2). Most of the so-called "speed art" is replete with complicated syntheses of a multitude of minute details, often depicting universal themes or mandalas. Speed users are frequently observed taking apart such objects as television sets, watches, radios, and phonographs. Subsequently, the parts may be analyzed, arranged, sorted, filed, and cataloged and, rarely, put back together (2). Many patients report a sense of satisfaction associated with this compulsive-like conduct.

Perhaps the best-known example of searching and examining behavior is that of Sherlock Holmes, whose cocaine habit was described by Dr. Watson:

> Finally he thrust the sharp point home, pressed down the tiny piston, and sank back into the velvet-lined arm-chair with a long sigh of satisfaction. Three times a day for many months I had witnessed this performance. . . .
>
> "It is cocaine," he [Holmes] said, "a seven-per-cent solution. . . . I suppose that its influence is physically a bad one. I find it, however, so transcendently stimulating and clarifying to the mind that its secondary action is a matter of small moment. . . .
>
> "My mind," he said, "rebels at stagnation. Give me problems, give me work, give me the most abstruse cryptogram, or the most intricate analysis, and I am in my own proper atmosphere. I can dispense then with artificial stimulants. But I abhor the dull routine of existence. I crave for mental exaltation. That is why I have chosen my own particular profession, or rather created it, for I am the only one in the world. . . .
>
> "To the trained eye there is as much difference between the black ash of a Trichinopoly and the white fluff of a bird's-eye as there is between a cabbage and a potato."
>
> "You have an extraordinary genius for minutiae," I [Watson] remarked (6, pp. 610–612).

Holmes's description of his "grooving on" puzzles and cryptograms and his penchant for magnificent synthesis of details to solve a given case are quite analogous to the amphetamine addict's intense curiosity and preoccupation with minutiae. Even at a low point in the drug-use cycle, these persons will seek out stimulating mechanical or intellectual puzzles. This compulsion for analysis is widely recognized in the "speed scene."

Amphetamine addicts frequently state that the early scanning, prying, probing behaviors subsequently evolve into a pleasurable sense of "suspiciousness" in the origi-

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the Behavioral Neuropharmacology Section, Department of Psychiatry, Duke University Medical Center, Durham, N.C. 27710, where Dr. Ellinwood is Director and Professor of Psychiatry, Dr. Sudilovsky is Research Associate, and Ms. Nelson is Senior Research Technician.

This work was supported by Public Health Service grants MH-07073 and MH-18904 from the National Institute of Mental Health and by funds from the Veterans Administration.

nal meaning of the word—that is, looking beneath the surface for the truth or meaning (literally, "to look from below"). They describe looking for meaningful details or relationships between details.

Another progressive symptom noted by these patients is increased thinking about "meanings and essences." Insights are frequently received as significant major revelations, or "eureka experiences." For example, one patient stated, "I put things together from the past and present. Now I think I know what is going to happen to this world." These sudden emotional insights and the compulsion to analyze a variety of details to find meaning and explanation were common to both philosophical and delusional concerns (2).

Later in the course of amphetamine addiction, the direction of the inquisitive behavior is reversed and the addict feels that other people are probing—watching and spying on him. At this time the previously pleasant suspiciousness takes a more paranoid form, leading eventually to fear or even agitation, hyperreactivity, and panic. The addict may then begin to misinterpret stimuli and often to have illusions and hallucinations. Thus it might be said that the initial periods of pleasurable curiosity and suspiciousness set the stage for the eventual paranoid reaction.

EXPERIMENTAL STUDIES IN ANIMALS

In the experimental laboratory, chronically intoxicated animals manifest evolving clusters of behavior comparable to those just described in amphetamine addicts (7). In our experiments we have used the operational approach that the laboratory observations have heuristic value in elucidating the nature of the amphetamine psychotic state itself; we are summarizing in this paper the animal behaviors that are analogous to those seen in human amphetamine abusers. The details of these experiments, performed on rats, cats, and rhesus monkeys, have been reported elsewhere (7–11).

Stereotypies

Stereotyped movements are the hallmark of both acute and chronic amphetamine intoxication. They may consist of a single activity performed continuously or a sequence of a few activities that dominate behavior (8, 12, 13). Usually these stereotypies appear nondistractible and "driven" (performed in a rapid, repetitious manner). They most often evolve from motor components of investigative behavior. In both our acute and chronic intoxication studies across species, the one common denominator of amphetamine-induced stereotyped movements was that they were composed of patterns of searching and examining (10). The motor components, at least, of these patterns are present in the stereotypies of all species studied.

In macrosmatic animals, such as the rat, the primary stereotyped mode is that of sniffing, although biting and licking are also noted. As one moves up the phylogenetic scale to cats, the sniffing movements remain, but head movements associated with looking are also prominent. In primates a new dimension, eye-hand examination patterns, is added. These hand movements are quite specific and consist primarily of forefinger probing, pincer-like grasping, picking, palm-clasping, and hand-examining. The underlying postural-motor components are similar in all of these motor activities. An individual motor component of the searching-examining patterns can be integrated into several stereotypies and may be directed either toward external objects or toward the animal's own body (as in patterns of grooming).

Over time, the stereotyped patterns become more repetitious and more constricted. Figure 1 illustrates the gradual constriction of a cat's head and neck movements that orient the head for visual regard. Over a period of two weeks, the orienting background movements often tend to drop out, leaving a small, pecking-like movement of the head in an extremely constricted pattern, as if the cat were sniffing at a small crumb or tiny morsel of food.

Attitudes and Postures

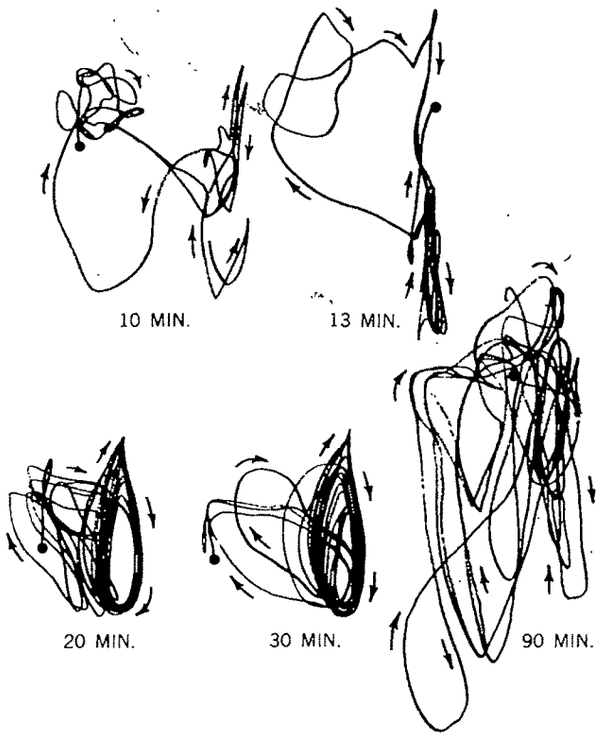
One of the most characteristic series of changes observed in cats during the period of chronic intoxication occurred in the animal's attitude.[1] The most frequent characteristic of early amphetamine intoxication was an abnormal investigative attitude—operationally defined as actively reaching out to or approaching restricted elements of the environment, with an excessively compulsive appearance. The evolution of the stereotyped motor behavior was intimately related to the abnormal investigative attitude (figure 2) and at times this attitude would persist in a given animal even after the motor stereotypy had ceased.

Another distinctive attitude, which appeared primarily in the later days of the intoxication cycle, was the reactive attitude—characterized by sudden, disproportionate startle reactions with a jumpy, agitated quality. This abnormal reactiveness was heralded by an increase in the speed and suddenness of movements and was later accompanied by a general increase in activity and agitation. At times the animals' movements were suggestive of akathisia and dyskinesia. In the end stages of the chronic intoxication cycle, even though the animal might be in a frozen posture, sudden orienting movements toward a real or "hallucinated" stimulus were often observed. Many animals appeared to be increasingly aware of minor stimuli in their environment and acutely apprehensive about it.

This intense hypersensitivity to the environment was a dramatic reversal of the complete disregard for transient environmental stimuli that characterized the abnormal investigative attitude. Although in the end stage much of the reactiveness appeared to be oriented toward "internal" cues, there was no question that minor external stimuli often overwhelmingly impinged on the animal in a way that triggered a fearful, overreactive orienting response. A slight, remote sound in the laboratory, for ex-

[1] In our studies "attitude" is operationally defined as body posture and activity in relation to the environment. This includes the animal's regard and reaction not only to his surroundings but also to his own body.

FIGURE 1
*Progress of the Tip of a Cat's Nose, Traced from a Slow-Motion Videotape**



*Each tracing represents 30 seconds of activity at the indicated time after the injection of amphetamine on day 1.

ample, might cause a violent turning of the head or jumping by a cat that ignored gross movements within its immediate field of vision. Or a glimpse of its own image on the shiny wall of the cage would cause a cat to jump back in apparent panic. Not infrequently a cat would jump back and turn vigorously to one side in response to a nonexistent (apparently hallucinatory) stimulus.

In the early days of intoxication, the persistent restrictiveness and directedness of the animals' behavior were reflected in their "postural-attitudinal" set as well as in their stereotyped movements. As intoxication progressed, however, there was increasing dissociation between the animals' underlying postural base and the superimposed movements and attitude. Toward the end of the intoxication period, a given animal might change his activity while maintaining the same posture—with the result that the behavior-posture relationship appeared dysjunctive and bizarre.

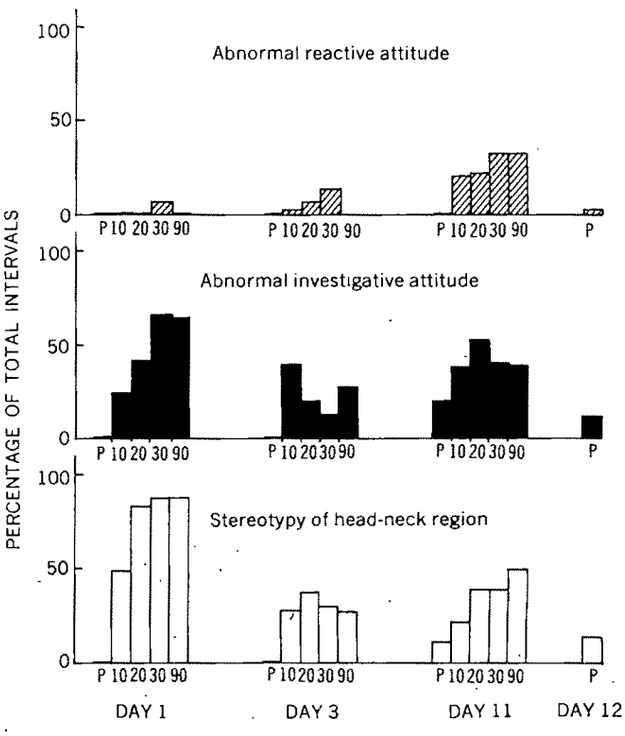
The last stage of intoxication was often characterized by akathisia-like repositioning and stepping movements that had the same agitated starting-and-stopping quality frequently noted in psychiatric patients with more chronic extrapyramidal manifestations induced by neuroleptic drugs. Toward the last day of the two-week study period many animals showed transient or adventitious movements that appeared to have little or no relationship to the main vector of behavior and that at times appeared incongruent to the overall behavioral configuration. The composite picture was one of hyperkinesia, in which the gradual breakdown of organized behavior accompanied an abnormally aroused and often fearful state.

DISCUSSION

Similarities Between Experimental and Clinical Amphetamine Intoxication

We have attempted to relate the progressive stages of chronic amphetamine intoxication in animals to the evolving stages of behavioral psychopathology observed in human amphetamine abusers. Because of their cognitive-perceptual nature, the symptoms most eminently related to the evolving paranoid psychosis are difficult to correlate directly with behavioral manifestations in lower animals. Remarkable similarities do exist, however, and in general it appears that the evolution of behavior in animal models is in many ways analogous to that noted in human patients. Table 1 presents our triple-layered

FIGURE 2
*Relationship Between Attitudes and Stereotypy During the Course of Amphetamine Intoxication**



*Each bar represents the occurrence of the behavior in a three-minute observation period on the indicated day during the preinjection period (P) or at ten, 20, 30, or 90 minutes after injection.

TABLE 1

Triple-Layered Analysis of Chronic Amphetamine Intoxication as a Model of Functional Paranoid Psychosis

Category	Early Stages	Intermediate Stages	End Stages
Functional paranoid psychosis	Paranoid tendencies		Paranoid psychosis
Human model psychosis (chronic amphetamine intoxication)	Curiosity: repetitious examining, searching, sorting behavior	Sustained pleasurable suspiciousness: looking for meanings, minutiae	Ideas of reference; persecutory delusions and hallucinations: fearful, panic-stricken, agitated, overreactive
Animal model psychosis (chronic amphetamine intoxication)	Abnormal investigatory attitude with repetitious activity	Restricted repetitious activity	Reactive attitude

model, in which amphetamine psychosis serves as a model of functional paranoid psychosis, and chronic intoxication studies in animals serve as a behavioral model of amphetamine psychosis.

The activities of many amphetamine abusers demonstrate a remarkable resemblance to patterns of examining behavior seen in animals. For example, amphetamine-induced repetitive "grooming behavior" in human addicts is not unlike that noted in rhesus monkeys. Usually it is manifested as incessant examining, rubbing, and picking (using the forefinger probe and pincer grasp), which often result in raw blemishes and in scars. Individual patients observed through a one-way screen sometimes spend hours examining and probing visually accessible parts of the body (9).

These same behaviors demonstrate the importance of the time dimension in the formation of delusions through the gradual organization of behavior, thought, and feeling about these acute experiences. Many patients who demonstrate grooming behavior, for example, develop marked delusions of parasitosis and spend many hours examining their skin and digging out imagined parasites. These delusions appear to develop out of early sequences of skin sensations and repetitive "grooming responses." Thus, in both man and lower animals, sequences of patterned behavior, such as the grooming response, take on an autonomy and centrality of their own. In man, the next step is the gradual cognitive development of a corresponding entrenched and stereotyped delusion (1).

Although he did not recognize the common mechanisms underlying automatic-compulsive behaviors and stereotyped expressions, Bleuler (14) listed a variety of repetitive behaviors that he called stereotypies. In these he included posture, movement, attitude, and thinking. He even mentioned stereotypies of drawing, music, writing, and speech (verbigeration). Bleuler considered these constrained modes of behavior most characteristic of catatonic schizophrenia, but he noted that they were also present in other forms of schizophrenia, including the paranoid type. We have previously discussed the many features that paranoid and catatonic schizophrenia have in common and their relationship to the amphetamine psychosis (7).

We have pointed out that a common attitudinal-postural mechanism may subserve both the motor stereotypies and the constricted perceptual and cognitive patterns (7, 15). We conceive of these postural mechanisms not as passive responses providing orientation in space but more as a vigorous outgoing behavior that is acting on and projecting sensorimotor apparatus onto the environment or as reaching out and selecting parts of space and objects to be seen, felt, and thought about. Qualitatively the nature of these mechanisms might fall somewhere between posture, attitude, and initiation of movement. These mechanisms could well initiate and coordinate the many modes of perceptual attention, including searching and orientation to the outside world; conversely, these mechanisms may direct attention between various external as well as internal cognitive sets.

An amphetamine-induced loss of initiative or distortion of the mechanisms that regulate the continuous flow of behavior is postulated as the factor underlying not only stereotypies but also the perseveration of perceptual-cognitive-attitudinal sets. Thus we found in our cats fixing of attention and attitudes as well as fixing of posture and patterned movements. In other words, the animal's attentive mechanisms are persistently directed to a certain aspect or part of the environment, even after the accompanying stereotypy has broken. These fixed attitudes are not unlike those observed in speed freaks who become "hung up" for hours, either on a puzzle or in examining-sorting compulsions, or in suspicious, repetitious scanning movements of the eyes. Thus, a marked tendency to maintain attitudinal sets, as well as the accompanying examining modes, is characteristic of chronic amphetamine intoxication in both man and animals.

By the same mechanism, thinking itself could become repetitious as a result of perseveration in one of the systems subserving perception and cognition. For example, it is possible that stimulation of a specific postural-attitudinal set might not only induce the motor components of grooming behavior but also tend to constrict perception toward the enhancement of minute objects and, in this way, potentiate the associated thinking process that leads to the delusion of parasitosis. By an analogous process, the scope of the all-pervasive attitude of curiosity and/or suspiciousness that characterizes incipient

paranoid schizophrenia or the beginning phase of amphetamine psychosis might become increasingly constricted until, under the influence of behavioral disorganization, increasing arousal, and/or fear, the individual's behavior evolves into a paranoid reaction.

Neurochemical Basis for Amphetamine-Induced Behaviors

Over the past several years there have been exciting developments in research attempting to fractionate the types of behavior induced by amphetamine intoxication and to ascertain which behavioral neurotransmitters mediate these specific behaviors. It has been demonstrated that amphetamine-induced release of the neurotransmitter dopamine, which is densely distributed throughout the nigro-neostriatal system (16, 17), is responsible for the stereotyped behavior (18–20), while norepinephrine mediates the amphetamine-induced hypermotility. The nigro-neostriatal dopamine system is known to have a marked effect on the postural and motor mechanisms associated with attention—a finding that is in keeping with the amphetamine-induced behavior observed in animals as well as in man.

Recent studies on animals with unilateral, lesion-induced degeneration of the nigro-neostriatal dopamine system have demonstrated that when L-dopa or amphetamine is administered to these animals there is spontaneous turning of the head to the side of the lesion and neglect of sensory stimuli or searching behavior on the contralateral side (21). In addition, McKenzie (22) has demonstrated that bilateral ablation of the olfactory tubercle in rats markedly reduces the sniffing stereotypy induced by stimulation of the dopamine receptors. The projection of the dopamine terminals into the olfactory tubercle (23)—the old motor nucleus of the olfactory brain—also fits well with the observation that amphetamine stimulates postural changes and head movements related to olfactory searching in macrosmatic animals.

Functionally there are additional indications that the rhinencephalic forebrain is mediating the type of behavior induced by amphetamine (15). Electrical stimulation of the pyriform cortex, the olfactory tubercle, the amygdala, and the insulo-orbital cortex produces various oral exploratory activities, such as rhythmic sniffing, gnawing, and licking movements (24). In man similar automatisms and rhythmical movements are accompanied by characteristic changes in consciousness in the course of psychomotor epileptic seizures. We have previously reported (15) that there is a dramatic similarity between the psychosis associated with temporal lobe epilepsy and amphetamine psychosis. Recently we have demonstrated that, following the blockade of norepinephrine synthesis, amphetamine induces a dramatic increase in rhinencephalic electrical activity, with subsequent seizures (25). More importantly, this catecholamine manipulation produces behaviors (e.g., reactive attitude) that are seen only at the end stages of chronic amphetamine intoxication.

In addition, it is now well known that haloperidol and pimozide, two drugs that primarily block dopamine receptors (26), are two of the most effective antipsychotic agents currently in use. Angrist and associates (27) have also demonstrated that d-amphetamine is only one to two times as potent as l-amphetamine in producing psychosis although the ratio of potency is 10:1 for other effects. This potency ratio for the elicitation of psychosis is quite consistent with the hypothesis of stimulation through dopaminergic mechanisms since there are similar dose-response relationships in producing experimental animal stereotypy (28) and in changing the comparative kinetics of the accumulation of norepinephrine and dopamine at synaptasomes (29).

Fuxe and Ungerstedt (30) have previously demonstrated that amphetamine-induced behavior is related not only to the type of catecholamine neurotransmitter activity, but also to the ratio of norepinephrine to dopamine. By appropriately blocking and stimulating norepinephrine and dopamine mechanisms, they demonstrated that a strong norepinephrine-to-dopamine ratio is associated with exploratory locomotor behavior; when the ratio is reversed, an exploratory stereotypy is produced. When norepinephrine is depleted and, in addition, dopamine activity is enhanced by the administration of L-dopa, the exploratory stereotypy becomes highly constricted and compulsive. Gunne and Lewander (31) have demonstrated that *acute* amphetamine intoxication in animals primarily depletes norepinephrine, whereas *chronic* amphetamine intoxication depletes both norepinephrine and (to a lesser degree) dopamine.

When both norepinephrine and dopamine are depleted, important behavioral effects are induced through loss of the righting reflexes (32), and the catecholamine receptors become supersensitive to such receptor stimulants as apomorphine (21). Thus catecholamine depletion may be quite important in setting the stage for a supersensitive response to amphetamine. It may be that the depletion of norepinephrine and/or dopamine, as well as the disturbance of the balance between the two neurotransmitters, may have so sensitized the catecholamine neurons that additional amphetamine stimulation produces the hyperreactive state observed in our cats both in the later stages of chronic amphetamine intoxication and following the blockade of norepinephrine synthesis.

In conclusion, it is important that the amphetamine psychosis be regarded as an *evolving* sequence of behaviors that appears in several stages and cannot be explained on the basis of a single neurotransmitter effect. The physiological as well as the behavioral state is qualitatively different in the various stages of chronic amphetamine intoxication. Thus, in the model psychosis based on chronic amphetamine intoxication, the effect of the drug in further stimulating the altered psychological state of an animal resulting from previous intoxication, as well as stimulating depleted supersensitive norepinephrine and/or dopamine neuronal systems, is qualitatively different from the effect of the drug on a naïve animal. This line of reasoning is consistent with our thesis that each evolving behavioral state of amphetamine psychosis provides a base for the subsequent manifestation of the psychosis.

REFERENCES

1. Ellinwood EH Jr: Amphetamine psychosis: a multidimensional process. Seminars in Psychiatry 1:208–226, 1969
2. Ellinwood EH Jr: Amphetamine psychosis, I: description of the individuals and process. J Nerv Ment Dis 144:273–283, 1967
3. Rylander G: Preludin-narkomener fran linish och medicinskkrimin olgisk synpundt. Svenska Lakarticha 63:973–980, 1966
4. Scher J: Patterns and profiles of addiction and drug abuse. Arch Gen Psychiatry 15:539–551, 1966
5. Kramer JC, Fischman VS, Littlefield DC: Amphetamine abuse: patterns and effects of high doses taken intravenously. JAMA 201:305–309, 1967
6. Doyle AC: The sign of the four, in The Annotated Sherlock Holmes. Edited by Baring-Gould WS. New York, Clarkson N Potter, 1967, vol 1, pp 610–688
7. Ellinwood EH Jr, Sudilovsky A: Chronic amphetamine intoxication: behavioral model of psychoses, in Psychopathology and Psychopharmacology. Edited by Cole JO, Freedman AM, Friedhoff AJ. Baltimore, Johns Hopkins University Press, 1972, pp 51–70
8. Ellinwood EH Jr, Escalante O: Chronic amphetamine effect on the olfactory forebrain. Biol Psychiatry 2:189–203, 1970
9. Ellinwood EH Jr: Effects of chronic methamphetamine intoxication in rhesus monkeys. Biol Psychiatry 3:25–32, 1971
10. Ellinwood EH Jr, Escalante O: Chronic methamphetamine intoxication in three species of experimental animals, in Current Concepts of Amphetamine Abuse. Edited by Ellinwood EH Jr, Cohen S. Washington, DC, US Government Printing Office, 1973, pp 59–68
11. Ellinwood EH Jr, Sudilovsky A, Nelson L: Behavioral analysis of chronic amphetamine intoxication. Biol Psychiatry 4:215–230, 1972
12. Randrup A, Munkvad I, Ulsen P: Adrenergic mechanisms and amphetamine-induced abnormal behavior. Acta Pharmacol 20:145–167, 1963
13. Randrup A, Munkvad I: Stereotyped activities produced by amphetamine in several animal species and man. Psychopharmacologia 11:300–310, 1967
14. Bleuler E: Textbook of Psychiatry. New York, Macmillan, 1924
15. Ellinwood EH Jr: Amphetamine psychosis, II: theoretical implications. Int J Neuropsychiatry 4:45–54, 1968
16. Anden NE, Dahlstrom A, Fuxe K, et al: Further evidence for the presence of nigro-neostriatal dopamine neurons in the rat. Am J Anat 116:329–333, 1965
17. Fuxe K, Hokfelt T: Catecholamines in the hypothalamus and pituitary glands, in Frontiers of Endocrinology. Edited by Ganong WF, Martini L. New York, Oxford University Press, 1969, pp 47–96
18. Randrup A, Scheel-kruger J: Diethyldithiocarbonnate and amphetamine stereotyped behavior. J Pharm Pharmacol 18:752–760, 1966
19. Fog RL, Randrup A, Pakkenberg H: Adrenergic mechanisms in corpus striatum and amphetamine-induced stereotyped behavior. Psychopharmacologia 11:179–183, 1967
20. Ernst AM, Smelik PG: Site of action of dopamine and apomorphine on compulsive gnawing behavior in rats. Experientia 22:837–845, 1966
21. Ungerstedt R: 6-hydroxy-dopamine-induced degeneration of central motor neurons. Eur J Pharmacol 5:107–110, 1968
22. McKenzie GM: Role of the tuberculum olfactorium in the rat. Psychopharmacologia 23:212–220, 1972
23. Escalante O, Ellinwood EH: Depletion of biogenic amines and enhancement of cholinergic activity in the olfactory bulb and central olfactory connections with chronic methedrine intoxication. Arquivos de Neuropsiquiatria 28(2):110–117, 1970
24. Monnier M: Functions of the nervous system, in General Physiology, Autonomic Functions. Edited by Monnier M. New York, Elsevier Publishing Co, 1968, pp 251–278
25. Ellinwood EH Jr, Sudilovsky A, Grabowy R: Olfactory forebrain seizures induced by methamphetamine and disulfiram. Biol Psychiatry (in press)
26. Janssen PAJ, Fernand TNA: Pimozide, a chemically novel, highly potent and orally long-acting neuroleptic drug. Arzneim Forsch 18:279–284, 1968
27. Angrist BM, Shopsin B, Gershon S: Comparative psychotomimetic effects of stereoisomers of amphetamine. Nature 234:152–153, 1971
28. Taylor KM, Snyder SH: Amphetamine: differentiation by d and l isomers of behavior involving brain norepinephrine or dopamine. Science 168:1487–1489, 1970
29. Snyder SH, Taylor KM, Coyle JT, et al: The role of dopamine in behavioral regulation and the actions of psychotropic drugs. Am J Psychiatry 127:199–207, 1970
30. Fuxe K, Ungerstedt U: Histochemical, biochemical, and functional studies on central monoamine neurons after acute and chronic amphetamine administration, in Proceedings of the Mario Negri Institute for Pharmacological Research. Edited by Costa E, Garattini S. New York, Raven Press, 1970, pp 277–288
31. Gunne E, Lewander T: Long-term effects of some dependence-producing drugs on the brain monoamines, in Molecular Basis of Some Aspects of Mental Activity. Edited by Wahaas O. New York, Academic Press, 1967, vol 2, pp 75–81
32. Ellinwood EH Jr, Escalante O: Behavior and histopathological findings during chronic methedrine intoxication. Biol Psychiatry 2:27–29, 1970

The Dream-Protein Hypothesis

BY ERNEST LAWRENCE ROSSI, PH.D.

Recent studies of learning and memory indicate that new experience is encoded by means of protein synthesis in brain tissue. The author reviews the literature on diet, nutrition, dreams, and REM sleep and finds support for the hypothesis that dreaming is a process of psychophysiological growth that involves the synthesis or modification of protein structures in the brain and that serves as the organic basis for new developments in the personality. The author outlines a series of experiments to further test the validity of this hypothesis. The implications of this research for a "growth" or "psychosynthetic" orientation in psychotherapy are discussed.

RECENT RESEARCH in the biology of learning and memory typified by the work of Hyden (1) indicates that new learning and behavior are encoded in the synthesis and/or modification of protein structures in brain cells. This statement of the relationship between biochemical events (protein synthesis) and behavior (new learning) is sufficient for behavior therapy but the language of psychodynamic psychotherapy requires the inclusion of phenomenological events. The relationship between phenomenological events and behavior is explored by the traditional methods of psychiatry and psychology (clinical interview, psychodiagnostic testing, etc.) but thus far the relationship between biochemistry and such events as dreams and fantasies has received little theoretical formulation or empirical support. This suggests the need for a dream-protein hypothesis: dreaming is a process of psychophysiological growth whereby dramas played out on a phenomenological level involve the corresponding synthesis and/or modification of proteins in the brain; this synthesis serves as the organic basis for new developments in the personality.

Studies that support the dream-protein hypothesis can be drawn from the vast body of research that uses rapid eye movements (REM) as the index of dreaming. These involve both the relationship between protein synthesis and dreaming and the relationship between dreaming and new developments in the personality.

Dr. Rossi is Extension Instructor, Department of Social Sciences, University of California at Los Angeles, and an analyst at the C.G. Jung Institute of Los Angeles; his address is 10486 Santa Monica Blvd., Los Angeles, Calif. 90025.

The author wishes to acknowledge the assistance of Ms. Jo Ann Boorkman, Computer Search Analyst, UCLA Information and Biographical Service Section, in obtaining a portion of the references for this paper through MEDLARS Computer Search no. 101726/R001, which was subsidized by the National Library of Medicine.

PROTEIN SYNTHESIS AND DREAMING

A MEDLARS computer search covering the research literature from January 1969 through June 1972 on the relationship of diet and nutrition to dreams and REM sleep yielded 181 citations, of which about 20 percent dealt with the relationship between protein synthesis and dreaming. The most direct evidence for this relationship in humans is the finding that alterations in protein metabolism achieved by either blocking or supplementing amino acids in the diet has an effect on dreaming. It has been found by Lester and colleagues (2), for example, that low-phenyl-alanine-tyrosine diets result in a systematic reduction in REM sleep. They then found this effect could be reversed so that the percentage of REM sleep was increased when tyrosine (in capsule form) was added to the diet. Furthermore, it has been found by other investigators (3) that tryptophane has a small but statistically significant effect in increasing REM sleep. The deprivation or supplementation of amino acids that are associated with ribonucleic acid (RNA) and protein synthesis is thus directly related to REM sleep in humans.

Our literature search turned up many more references to experimental work with animals than with humans. The general finding documented by numerous animal studies (4–7) supports the finding of the studies with humans, i.e., that deprivation or supplementation of amino acids in the diet results in corresponding effects on REM sleep. In no case, however, was there a study designed specifically to evaluate this relationship. Most of the studies were motivated by interest in the neurochemical origin of REM sleep, the role of amino acids in the transmission of the nervous impulse, or the action of monoamine oxidase inhibitors on REM sleep, rather than by the concept embodied in the dream-protein hypothesis. Although the results of these studies are all in the direction that would be predicted by the dream-protein hypothesis, new studies specifically designed to test the validity of the hypothesis are now called for. Three general approaches to validating the dream-protein hypothesis seem possible.

1. In table 1, the three-stage process in the synthesis of proteins from amino acids and RNA is outlined, together with a listing of some of the metabolites and chemical agents that have been used (8, 9) to facilitate or retard each stage in learning and memory experiments. In general the dream-protein hypothesis would predict that agents that facilitate any stage of protein synthesis would tend to increase REM sleep, while those agents which block a stage of protein synthesis should decrease REM sleep. This prediction has been amply verified at the

amino acid stage but not at stages closer to the synthesis of RNA and proteins. Such verification would be needed to further confirm or disprove the dream-protein hypothesis.

2. During the past decade, innovations in biochemical analysis that permit the isolation and measurement of extremely small amounts of macromolecular RNA, of such enzymes as cholinesterase (10), and of neural growth factors (11) have enabled researchers to determine how these substances affect memory and learning. In essence these studies indicate that new developments in learning and behavior may be associated with changes in the synthesis and/or structure of RNA. If researchers can now detect changes in the presence of RNA, cholinesterase, or neural growth factors at the locus of dream activity (e.g., the visual cortex) during the REM state, they will have provided further support for the dream-protein hypothesis.

3. The relationship between protein intake and dreaming has been more difficult to describe. Although extreme protein deprivation does result in EEG abnormalities (2), I have not yet found any studies dealing directly with the relationship between the deprivation of protein or protein precursors (apart from the amino acid studies cited above) and REM sleep. Three types of research could clarify this relationship: 1) neuroanthropological studies of the effect of extreme protein deprivation on the REM sleep of population groups that are subject to these specific types of malnutrition (12); 2) REM studies on people who subject themselves to macrobiotic diets that are deficient in proteins (my preliminary interviews with a number of such people yielded the expected subjective report of decreased dreaming or dream recall while they were on such diets); and 3) animal studies that relate protein and amino acid deprivation to REM sleep (13).

TABLE 1
Agents That Have Been Used to Facilitate or Block Protein Synthesis

Item	Increase Uptake or Synthesis	Block Uptake or Synthesis
Amino Acids	Dietary amino acids: tryptophan, tyrosine, etc.	Amino acids restricted
RNA	Yeast RNA, malononitrile, magnesium pemoline (?), soluble RNA	8-azaquanine, actinomycine-D
Protein	Dietary proteins, malononitrile (dimers and trimers)	Restricted diets, puromycin, puromycin amino nucleoside, cycloheximide

DREAMS AND PERSONALITY DEVELOPMENT

Just as Snyder (14) has organized many of the diverse and apparently unrelated findings of REM research into an evolutionary theory of dreaming on the phylogenetic level, we may also apply the findings of much REM-related research to the ontogenetic development of the individual's personality. I shall summarize those findings which bear upon the integrative or psychosynthetic functions of REM sleep that are most directly relevant to the dream-protein hypothesis.

1. Dreaming is initiated and primarily regulated by internal brain processes rather than by external stimuli from the environment (15). That is, dreaming is a process that is important for internal developments within the brain itself rather than for handling external stimuli. In an evolutionary theory of dreaming, Snyder expressed this conception well:

> [The REM state] is not a condition of partial arousal intermediate between sleep and waking, but now appears to be among the most extraordinarily intense activations yet discovered in the normal functioning of the central nervous system. Although similar in many respects to highly aroused waking, there are good reasons for thinking that the functional organization of central nervous activity is quite different from waking, and that the stimulus which originates this activation is intrinsic to the brain itself (14, p. 123).

Meissner (16) has outlined the neurophysiological mechanisms characteristic of REM activation that "suggest that the striking activation of limbic structures in rhombencephalic sleep has a specific integrative function which serves to maintain the effective organization and integration of emotional and cognitive experience." The conclusion therefore seems inescapable: the state of dream consciousness concerns the organization and synthesis of internal data (e.g., personality development), while the awake state of consciousness deals primarily with the processing of external sensory data from the environment.

2. The REM state occupies up to 50 percent of the sleep time of neonates and children (at ages when learning and personality formation is greatest) and then decreases to 20 to 25 percent with increased age, as the capacity for new learning and personality growth becomes relatively less (17).

3. Recent studies (18) of the dreams of children and adolescents indicate that the typical dreams of normal children revolve about recreational activities and as such "appear most simply to represent extensions of the child's waking ego impulses to exploration and manipulation of the environment." The REM state can thus be understood as a period during which internal programs are being synthesized and consolidated so they can later be actualized in personality and behavior change.

4. Dement and associates (19) have recently summarized findings from their laboratory which demonstrate that REM sleep is necessary for the optimal control and integration of drive systems (aggression and sex) in laboratory animals even though it is not necessary for life itself. Recently Hartmann and his co-workers (20) have concluded from studies with humans that "psychic pain or psychic disequilibrium with changing defense patterns" are associated with an increase in REM sleep. The

subject who required more REM sleep "is relatively anxious and depressed, and his life style involves change and worry." These conclusions are exactly what one would expect if dreams had a psychosynthetic function in maintaining the growth and stability of the ego, since more REM sleep would be required during periods of more active personality growth, change, and stress.

5. Recent studies of the correlation between REM sleep and the process of change in psychotherapy provide interesting confirmation for the above. Freedman and associates (21), for example, reported that "striking and consistent correlations were discovered between the length of the fourth dream period and the [psychotherapy] session variables of self-satisfaction, wish fulfillment, elation, and control." I have discussed elsewhere how these types of variables can be understood as indications that a process of psychological growth (psychosynthesis) is taking place (22). This type of study thus tends to confirm that there is a direct relationship between dreaming and personality growth as stipulated by the dream-protein hypothesis.

PSYCHOTHERAPEUTIC IMPLICATIONS

Validation of the dream-protein hypothesis would provide a biological basis for modern theories of personality change, growth, and development. Most workers have been so overwhelmed by Freud's concept of psychoanalysis that they have tended to overlook psychosynthetic processes. Just as the biochemical basis of life may be conveniently divided into anabolic and catabolic processes, so one may posit a dynamic equilibrium within the phenomenological realm between psychosynthetic processes (whereby entirely new and more complex psychological experiences are created) and analytic processes (whereby a breakdown of inner experience into simpler parts is evident).

The growth or psychosynthetic orientation is actually the common denominator of a very wide range of the apparently diverse "schools" of psychotherapy that have developed since Freud (23). Apart from the ideas of such early ego psychologists in the Freudian psychoanalytic framework as Hartmann, Kris, and Lowenfeld, Jung's central concept of individuation, Adler's concept of the creative self, and Rank's emphasis on the artist-type may all be understood as efforts to explore the synthetic or creative aspects of personality development. The existential approaches of Binswanger, May, and Frankl emphasize the complex coping methods by which a person actually creates his existence and world view. In recent years the client-centered, humanistic, and gestalt psychologists have all elaborated approaches and attitudes toward psychotherapy that focus on a growth orientation.

While the growth orientation frequently has been presented in a global and loosely defined manner by many of these theorists, the psychosynthetic approach of Assagioli (24) and the autogenic meditation methods of Schultz and Luthe (25) have introduced a certain degree of precision and scientific control in facilitating personality development. Assagioli, for example, has pioneered in the development of "meditation" methods by which the patient allows his imagination to elaborate a standard series of emotionally significant patterns of internal imagery. This elaboration of internal imagery may have important diagnostic significance; more importantly, however, the growth-oriented therapist uses this approach to facilitate the actual synthesis of new psychic structures that can become the nuclei for new developments in the personality. I have recently extended this approach by illustrating in detail how symptoms of "psychopathology" can be understood as breakdowns in the natural processes of personality development (22). This analysis of these psychosynthetic processes, as outlined in a series of "phenomenological equations," suggests how they may be used to develop further approaches to facilitating personality development in psychotherapy.

The obvious drawback of the phenomenologically oriented growth approaches to psychotherapy is that they lack the foundation in biology and chemistry that most workers since Freud consider so important for any psychodynamic psychology. Concepts of libido, genetic determination, hormonal regulation, imprinting, and most of the other current variables of biological psychiatry are sometimes useful in dealing with the global or molar aspects of personality but they are obviously unable to account for the intricate variability found in individual fantasies and dreams that continually change with life experience. The dream-protein hypothesis is a means of directly relating these subjective events of personality growth to biochemical events. If the dream-protein hypothesis can be further validated it would be a major step in establishing a biochemical foundation for personality dynamics.

REFERENCES

1. Hyden H: The question of a molecular basis for the memory trace, in The Biology of Memory. Edited by Pribram K, Broadbent D. New York, Academic Press, 1970, pp 101–119
2. Lester B, Chanes R, Condit P: A clinical syndrome and EEG-sleep changes associated with amino acid deprivation. Am J Psychiatry 126:185–190, 1969
3. Hartmann E: The pharmacology of dreaming sleep and its psychiatric implications, in The Psychodynamic Implications of the Physiological Studies on Dreams. Edited by Madow L, Snow L. Springfield, Ill, Charles C Thomas, 1970, pp 47–70
4. Karadzic V, Micic D, Rakic L: Alterations of free amino acid concentrations in cat brain induced by rapid eye movement sleep deprivation. Experientia 27:509–511, 1971
5. Davis J, Himwich W, Stout M: Cerebral amino acids during deprivation of paradoxical sleep. Biol Psychiatry 1:387–390, 1969
6. Francesconi R, Mager M: Effects of sleep deprivation on the periodicity of tyrosine metabolism in mice. Experientia 27:1273–1274, 1971
7. Haulica I, Ababei L, Teodorescu C, et al: The influence of deprivation of paradoxical sleep on cerebral ammonia metabolism. J Neurochem 17:823–826, 1970
8. Gurowitz E: The Molecular Basis of Memory. Englewood Cliffs, NJ, Prentice-Hall, 1969
9. Gaito J (ed): Macromolecules and Behavior, 2nd ed. New York, Appleton-Century-Crofts, 1972
10. Krech D, Rosenzweig M, Bennett E: Chemical and anatomical

plasticity of the brain. Science 146:610–619, 1964
11. Levi-Montalcini R: Growth control of nerve cells by a protein factor and its anti-serum. Science 143:105–110, 1964
12. Stoch M, Smythe P: Undernutrition during infancy and subsequent brain growth and intellectual development, in Malnutrition, Learning, and Behavior. Edited by Scrimshaw N, Gordon J. Cambridge, Mass, MIT Press, 1968, pp 278–289
13. Gordon M, Deanin G: Mitochondria and lysosomes: a proposal on the protein nutrition of the synapse. Ibid, pp 136–150
14. Snyder F: Toward an evolutionary theory of dreaming. Am J Psychiatry 123:121–136, 1966
15. Dement W: An essay on dreams: the role of physiology in understanding their nature, in New Directions in Psychology, vol 2. Edited by Barron F. New York, Holt, Rinehart, and Winston, 1965, pp 93–114
16. Meissner W: Dreaming as process. Int J Psychoanal 49:63–79, 1968
17. Roffwarg H, Muzio J, Dement W: Ontogenetic development of the human sleep-dream cycle. Science 152:604–609, 1966
18. Foulkes D, Larson J, Rardin M: Two studies of childhood dreaming. Am J Orthopsychiatry 39:627–643, 1969
19. Dement W, Cohen H, Ferguson J, et al: A sleep researcher's odyssey: the function and clinical significance of REM sleep, in The Psychodynamic Implications of the Physiological Studies on Dreams. Edited by Madow L, Snow L. Springfield, Ill, Charles C Thomas, 1970, pp 71–123
20. Hartmann E, Baekeland F, Zwilling G, et al: Sleep need: how much and what kind? Am J Psychiatry 127:1001–1008, 1971
21. Freedman A, Luborsky L, Harvey R: Dream time (REM) and psychotherapy. Arch Gen Psychiatry 22:33–39, 1970
22. Rossi E: Dreams and the Growth of Personality. New York, Pergamon Press, 1972
23. Rossi E: Game and growth: two dimensions of our psychotherapeutic zeitgeist. Journal of Humanist Psychology 7:139–154, 1967
24. Assagioli R: Psychosynthesis: A Manual of Principles and Techniques. New York, Hobbs Durman, 1965
25. Schultz J, Luthe W: Autogenic Therapy, vol 1. New York, Grune & Stratton, 1969

The Manfred S. Guttmacher Award

The American Psychiatric Association invites applications for its annual Manfred S. Guttmacher Award for 1974. The award is given for any outstanding contribution to the literature of forensic psychiatry in the form of a book, monograph, paper, or any other work, including audiovisual presentations, submitted to or presented at any professional meeting or published during the year ending December 31, 1973. The award, which includes an honorarium of $250 and a plaque, will be presented at the Convocation of Fellows at the annual meeting in Detroit, Mich., May 1974.

Anyone who wishes may apply to receive the award by submitting five copies of the work as well as five abstracts to Jonas Rappeport, M.D., Chairman, Guttmacher Award Board, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Entries will be acknowledged but will not be returned.

The deadline for submissions is January 1, 1974, and to be considered any entry must be in Washington by that date.

Indian Education: A Human Systems Analysis

BY CARL A. HAMMERSCHLAG, M.D., CLAYTON P. ALDERFER, PH.D., AND DAVID BERG, M.A.

The problems of Indian boarding schools are examined in the light of both systems theory and data from interviews and questionnaires conducted at one school. The authors conclude that the schools have failed to define their primary task—to educate or to handle children with behavior problems. More importantly, the impact of the whole educational system perpetuates the Indians' powerlessness and dependency on the government. The authors express the hope that, if there is more community involvement in the schools, this will lead to greater assumption of responsibility by Indians in other spheres.

THE BUREAU OF INDIAN AFFAIRS (BIA), charged with the education of American Indians, today operates more than 200 schools in 17 states. Of the approximately 200,000 school-age Indian children, 35,000 are in BIA boarding schools, 16,000 are in day schools, and 24,000 are housed in BIA dormitories while attending public schools. Of the 35,000 children in boarding schools, more than 12,000 attend off-reservation boarding schools, which for the most part provide a high school education for Indian children who have completed the eighth grade. The remainder are in on-reservation boarding schools; 8,000 of these are elementary school students, nine years old or under (1). Enrollment in BIA boarding schools is increasing; indeed, it has doubled in the 1960s.

The history of the boarding school experience, its inadequacies, and its archaicisms were first commented upon by Merriam in 1928 (2). Studies since have concluded that, as the cultural and educational backgrounds of Indian children become more like those of white children in public schools, the educational achievement of Indian children will more closely match that of white children (3–5). To many Indian people that implies a not very subtle attempt to sow the seeds of cultural dissolution, to use the schools as an instrument of Indian cultural annihilation. There are still rituals among tribes today to cleanse their children of white contamination on their return from boarding schools. This study explores the impact of a boarding school system on both students and staff members who live, learn, and work there.

Read at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Hammerschlag is Mental Health Consultant, Indian Health Service, 4212 North Sixteenth St., Phoenix, Ariz. 85016. At the time of this study, Dr. Alderfer and Mr. Berg were both with the Department of Administrative Sciences, Yale University, New Haven, Conn., where Dr. Alderfer is Associate Professor and Mr. Berg was a graduate student.

THE SCHOOL SYSTEM

The school studied, located in a major southwestern urban setting, has approximately 700 students, aged 14 to 22 years, and 200 staff members. All the students are Indians; most of the teaching and administrative personnel are non-Indian. At least 60 percent of the student body enters this boarding school for so-called "social reasons," which include extreme poverty, large families, language difficulties, and behavior problems in other schools. Because so many children come to the school for these reasons, there is considerable ambiguity among the staff as to whether the primary mission of the school is one of behavioral control or teaching.

For example, the dormitory attendants, who are charged with the management of 120 students per dorm, see their jobs as maintaining order and resolving immediate crises. The teaching staff see their roles as instructional, but students who do well in class are not necessarily the ones who also behave well outside the classroom. There is little interpenetration of the boundaries between these distinct task groups at any time. When it does occur, it usually concerns decisions about the dismissal of students with behavior problems. If the greatest articulation of structure exists for a secondary task of the system (such as behavioral control) and the purported primary task (i.e., education) remains isolated, the system is in trouble.

The concept of boundary is an aspect of open systems theory that treats organizations as systems whose survival requires the continuous exchange of materials with the environment (6–8). If the boundary is too permeable it invites inundation, chaos, and disorganization, whereas an impermeable boundary becomes a barrier that causes death through entropy. There are boundaries that separate the organization from its environment and those which are internal to the organization. These internal boundaries separate task systems from each other. The authority for these separate internal operations (dorm, teaching, guidance) is delegated by top management to subordinates. The viability of the subsystem, and ultimately of the total organization, is dependent on successful boundary transactions between these adjacent subsystems.

In the school's case, each subsystem functions as if it were totally independent and involved in tasks that are perceived as mutually exclusive. For example, a dormitory head telephoned a guidance counselor at midnight to say that a student was drunk and disorderly and asked that he come over right away. The counselor replied, "I don't think I can do much counseling with the student in

Health is a research hospital and accepts patients only upon referral from a physician, our sample may not be representative of the general population of depressed patients.[3] Nevertheless, our data support the hypothesis that many depressed patients are referred to hospitals without adequate trials of antidepressant drugs as outpatients. Perhaps many hospitalizations could be averted if antidepressants were better used.

While some patients may not receive adequate drug therapy because of the sudden onset of their illness and emergency referral, the attitudes and behavior of the prescribing physician may be responsible. In some instances there may be a bias against the use of drugs in favor of psychotherapy alone. In others, unfamiliarity with antidepressants and fear of side effects may account for their not prescribing these drugs or prescribing them only at low dosages. Incorrect diagnoses, as well as a lack of knowledge of the usefulness of antidepressants, might also contribute to the use of the wrong drugs.

One factor that may have contributed to the low dosage of tricyclics in some of these cases was the use of fixed proprietary combinations. Five patients in the group that had been inadequately treated were receiving fixed combinations of perphenazine and amitriptyline (Triavil). For this combination to be effective, either 12 or 24 mg. per day of perphenazine[4] must be given to achieve a minimally effective dosage (150 mg./day) of amitriptyline. Physicians may be reluctant to administer this much phenothiazine to a patient with primarily depressive symptoms.

It is tempting to suggest that the further education of physicians is the solution to the problem of inadequate drug treatment of depression by physicians in the community. In fact, this may be a partial answer. However, information on antidepressants and their use has long been available and is presumably incorporated into existing medical school, residency, and continuing education curricula. If our suggestion for a larger study of the actual patterns of drug prescription in the community is followed, perhaps information on the causes of inadequate drug treatment could be obtained and recommendations made accordingly.

CONCLUSIONS

Our clinical impression that many depressed patients are referred for hospitalization before they receive adequate drug treatment as outpatients was confirmed in a sample of 51 consecutively admitted depressed patients at the National Institute of Mental Health. Only 20 percent of our sample were receiving drug treatment that was adequate for depression at the time of their referral. Twenty-five percent were receiving antidepressants at dosages lower than those generally considered effective. Eighteen percent received drugs other than antidepressants and 37 percent were not receiving drugs. Of those patients in our sample who were treated with adequate dosages of antidepressants in the hospital, two-thirds responded. Our data suggest that many depressed patients in the community may not be receiving adequate drug treatment for their illnesses.

Inadequate drug treatment for depression may result from the physician's unfamiliarity with or bias against use of these drugs. We suggest that a larger study of actual patterns of drug prescription in the community be undertaken to confirm our preliminary findings and to seek the causes for inadequate drug treatment, so that appropriate educational programs can be undertaken. Adequate drug treatment of depressed patients may in many cases obviate the need for hospitalization.

REFERENCES

1. Dunner DL, Gershon ES, Goodwin FK: Heritable factors in affective illness (abstract), in Scientific Proceedings of the American Psychiatric Association in Summary Form. Washington, DC, APA, 1970, p 187
2. Bunney WE, Hamburg DA: Methods for reliable longitudinal observation of behavior. Arch Gen Psychiatry 9:280–294, 1963
3. Klein DF, Davis JM: Diagnosis and Drug Treatment of Psychiatric Disorders. Baltimore, Williams & Wilkins, 1969
4. Goodwin FK, Murphy KL, Dunner DL, et al: Lithium response in unipolar versus bipolar depression. Am J Psychiatry 129:44–47, 1972
5. Hollister LE, Overall JE: Reflections on the specificity of action of antidepressants. Psychosomatics 6:361–365, 1965
6. Hollister LE: Choice of antipsychotic drugs. Am J Psychiatry 127:186–190, 1970

[3] The Laboratory of Clinical Science of the National Institute of Mental Health attempts to select patients with primary affective illness that is uncomplicated by other psychopathology or medical illness.

[4] Equal to approximately 120–240 mg. of chlorpromazine (6).

Single Versus Divided Daily Dose of Trimipramine in the Treatment of Depressive Illness

BY M.Z. HUSSAIN, D.P.M., AND Z.A. CHAUDHRY, M.B.

A group of 56 patients with depressive illnesses were administered either a single daily dose or a divided daily dose of trimipramine on a random basis. Results of the treatment showed several advantages for the use of a single daily dose: a trend toward better therapeutic improvement, a significant decrease in the side effects of insomnia and fatigue, and more regular consumption of the medication.

A COMMON PRACTICE in the pharmacotherapy of depressive illness is to prescribe antidepressants in three or four divided doses during the day. Such a practice does not seem to have a scientific basis. Although single daily doses have been recommended for tricyclic antidepressants (1–4), few studies have systematically evaluated a single versus a divided regimen of these drugs.

This investigation was designed to examine the differences in divided and single dose administration of trimipramine in treating depressive illness. Trimipramine is a tricyclic antidepressant of proven efficacy (5, 6) and comparatively few side effects.

METHOD

Fifty-six patients of both sexes suffering from depressive illnesses, with major depressive symptoms including retardation, agitation, anxiety, sleep disturbance, or somatic complaints, were admitted to the trial. All patients were under 65 years of age. Seventy-five 100 mg. scored tablets of trimipramine were dispensed to each patient in a sealed envelope containing directions for taking the medication. The patients received instructions to take either divided doses of half a tablet (50 mg.) twice a day for the first day and four times a day thereafter or a single dose of one tablet (100 mg.) on the first night and two tablets (200 mg.) each night thereafter. These instructions were enclosed in the envelopes in random order and the envelopes were marked without the therapist's knowledge. After the trial period of four weeks the tablets that were returned unused were counted and the number recorded.

Before commencing treatment, each patient's symptoms were evaluated on the basis of the Hamilton Rating Scale for Depression (7) and the Zung Self-Rating Depression Scale (8). These scales were administered again after two and four weeks of treatment.

The authors are with the Psychiatric Centre, Victoria Union Hospital, 1200-24th St. West, Prince Albert, Sask., Canada, where Dr. Hussain is Senior Psychiatrist and Dr. Chaudhry is a resident in psychiatry.

RESULTS

Four of the 56 patients initially treated discontinued use of the drug during the first week of treatment because of side effects. Two other patients dropped out and did not complete the treatment, and one patient was withdrawn in the first week for treatment with ECT because of the increasing severity of his depression and suicidal preoccupation. Of the remaining 49 patients, 26 were in the single-dose regimen (SDR) group, and 23 were in the divided-dose regimen (DDR) group. A comparison of the two groups by age, sex, and duration of illness is presented in table 1.

The number of tablets returned was subtracted from 75 (the number issued) and this figure was divided by the number of days in the trial. This gave the patients' presumed daily consumption of the drug during the trial period of treatment. The mean daily consumption rate for the SDR group was 181 mg., and for the DDR group, 162 mg.

The mean scores of the two groups on the Hamilton Rating Scale and the Zung Self-Rating Depression Scale are shown in table 2. For the Hamilton Rating Scale, the comparison of pretrial scores with scores of the two later periods of treatment shows a significant improvement during the trial period. The difference between the two groups did not reach a significant level, but a trend toward a better response was present in the SDR group.

TABLE 1
Characteristics of Single (SDR) and Divided (DDR) Treatment Groups

Characteristic	SDR Group (N = 26)	DDR Group (N = 23)
Sex		
Men	9	7
Women	17	16
Age (mean±S.D.)	42.2±8.4	44.9±9.7
Duration of illness (in months)	7.2±5.6	6.6±6.1

TABLE 2
Comparison of Group Scores on Depression Scales Over Treatment Period

Treatment Period	Hamilton Rating Scale		Zung Self-Rating Scale	
	SDR Group Mean±S.D.	DDR Group Mean±S.D.	SDR Group Mean	DDR Group Mean
Initial	27.3±6.7	26.2±6.4	63	61
Two weeks	12.4±6.1	16.5±7.8	43	48
Four weeks	9.3±3.8	11.2±4.5	34	36

There were no significant intergroup differences in the mean Zung Scale scores initially. At the end of four weeks the mean Zung Scale scores were within the normal range. The same trends were observed when the mean scores of the 20 items of the Zung Scale were grouped to measure affective, biological, and psychological symptoms.

The effect of the treatment on individual symptoms was measured by calculating the proportion of patients completing the trial in each group who were free of particular symptoms at the end of each assessment. A significant result was that in the second week's assessment the symptoms of insomnia and fatigue decreased most in the SDR group.

All symptoms associated by the patients with drug intake and reported spontaneously by the patients regardless of whether or not the therapist agreed were defined as side effects. Patients were asked to report any effects from the medication, yet no specific inquiry into such reactions was made. Some patients had multiple side effects. Four patients withdrew from the investigation because of side effects, three of whom were on divided doses. Two of these patients complained of dizziness, blurred vision, and sleepiness, and one complained of depersonalization and inability to concentrate or think clearly. The fourth patient, who was on a single nightly dose, complained of inability to wake up in the morning and excessive drowsiness. Table 3 shows the data on side effects. All patients received routine physical examinations and laboratory tests as well as complete blood counts and urinalysis at the beginning and end of the trial. These tests showed no abnormal findings.

DISCUSSION

Although there is much variation in the rate of metabolism of the tricyclic antidepressants among individuals, generally the absorption after ingestion is remarkably prompt. Maximum absorption takes place in the first 30 to 60 minutes after oral administration. Following this period the fall in serum level is rapid, and after a few hours even a massive overdose will produce only minute traces in the bloodstream (9). Normally 40 to 50 percent of a single dose can be recovered from the urine within four days, either as the drug itself or as one of its metabolites. Most of the drug is stored in body tissues; relatively high levels are found in neuronal tissue. These compounds do not leave the brain by simple diffusion into the bloodstream, where the concentration is low, but are released gradually from neuronal storage sites as they reform.

It seems evident that divided doses are not necessary for effective absorption and that therapeutic effects can be achieved adequately with single daily doses. Our results indicate an advantage for patients who received single nightly doses of trimipramine compared with those receiving divided doses. Although the difference in beneficial therapeutic result did not reach a level of significance, the depressive symptoms of insomnia and fatigue were significantly affected.

The incidence of side effects was significantly low. The higher incidence of side effects with divided doses could possibly be due to greater fluctuation in the level of the drug found in the serum after repeated doses. A significant positive correlation has been found between the level of tricyclic antidepressants in the plasma and their subjective side effects (10). A transient sedative effect that usually occurs between 30 and 60 minutes after oral administration of the drug may hinder the patient's activities during the daytime, but the same effect becomes most desirable at night, since insomnia is a troublesome feature of depressive illness. Administration of the drug at night also makes prescription of hypnotics unnecessary, thus reducing treatment cost and preventing possible interaction between different medications.

In this investigation single-dose consumption was more regular than consumption for repeated doses, confirming previous findings (11, 12) that a regimen consisting of a single daily dose is more reliable than one consisting of multiple doses. A single dose is more convenient for the patient and staff and gives nurses more time to take an active therapeutic role in patient care. A large single dose is also less expensive than its equivalent amount in divided doses.

The results of this investigation suggest that it is not necessary to give tricyclic antidepressants in divided

TABLE 3
Number of Patients Reporting Side Effects of Trimipramine for Two Treatment Groups

Side Effects	SDR Group	DDR Group
Drowsiness	3	8
Blurred vision	2	5
Dizziness	3	9
Dry mouth	5	7
Feelings of unreality	0	1
Headache	0	1
Indigestion	1	2
Nausea	0	3
Stuffy nose	2	3
Shakiness	1	3
Trouble voiding	0	0
Constipation	1	4
Total impotence	0	1

doses or to use sustained-release preparations (13) in order to achieve therapeutic effectiveness. Dosage should be 150 mg. or above, as smaller doses are probably too low to have much therapeutic effect (14, 15).

REFERENCES

1. Klein DF, Davis J: Diagnosis and Drug Treatment of Psychiatric Disorders. Baltimore, Williams & Wilkins Co, 1969
2. Kramer JC: Single daily dose schedule of imipramine. Compr Psychiatry 3:191–192, 1962
3. DiMascio A, Shader RI: Drug administration schedules. Am J Psychiatry 126:796–801, 1969
4. Saraf K, Klein DF: The safety of a single daily dose schedule for imipramine. Am J Psychiatry 128:483–484, 1971
5. Salzmann MM: A controlled trial with trimipramine, a new antidepressant drug. Br J Psychiatry 111:1105–1106, 1965
6. Kristof FE, Lehmann HE, Ban TA: Systematic studies with trimipramine, a new antidepressant drug. Can Psychiatr Assoc J 12:517–520, 1967
7. Hamilton N: A rating scale for depression. J Neurol Neurosurg Psychiatry 23:56–62, 1960
8. Zung WWK: A self-rating depression scale. Arch Gen Psychiatry 12:63–70, 1965
9. Lewis SA, Oswald I: Overdose of tricyclic antidepressants and deductions concerning their cerebral action. Br J Psychiatry 115:1403–1410, 1969
10. Asberg M, Cronholm B, Sjoqvist F, et al: Correlation of subjective side effects with plasma concentrations of nortriptyline. Br Med J 4:18–21, 1970
11. Coppen A, Bailey JE, White SG: Slow release lithium carbonate. J Clin Pharmacol 9:160–162, 1969
12. General Practitioner Research Group: Dosage schedules in general practice. Practitioner 204:719–723, 1970
13. Sims CP: Trial of a sustained release form of amitriptyline in the treatment of depressive illness. Br J Psychiatry 120:65–67, 1972
14. Braithwaite RA, Goulding R, Theano G, et al: Plasma concentration of amitriptyline and clinical response. Lancet 1:1297–1300, 1972
15. Blashki TG, Mowbray R, Davies B: Controlled trial of amitriptyline in general practice. Br Med J 1:133–138, 1971

"The Fitness Factory," Part I: The Psychiatrist's Role in Determining Competency

BY ROBERT LLOYD GOLDSTEIN, M.D.

This article is the first in a series on the work of the New York City Forensic Psychiatry Clinic, which performs mental competency evaluations of defendants appearing before the New York City Criminal Court. The author describes the clinic's philosophy regarding competency and contrasts its roles before and after the enactment of the new Criminal Procedure Law that granted considerably broader powers to the clinic.

> The psychiatrists, as usual, will not agree about him, they will argue in front of a jury who will not understand what it is all about, and there is every chance that he will get the benefit of the doubt, in which case he will be sent to spend the rest of his days in an asylum.
>
> —SIMENON (1, p. 137)

THROUGH A COMBINATION of historical accident, social evolution, and pragmatic necessity, the infant science of psychiatry has become an inextricable cog in the machinery of the law, just as it has become a sometimes embarrassing but firmly entrenched member of the medical-scientific community. A learned and distinguished body of jurists, legal historians, forensic psychiatrists, and other social critics has seriously questioned the wisdom of a growing tendency to attribute to psychiatrists inflated powers of diagnosis and prediction in what is still an uncharted and poorly understood area—the interface of psychiatry, law, and society (2–4).

Nevertheless, with increasingly crowded courtrooms, greater pressure to understand and control antisocial patterns, and the widespread myth (unfortunately not limited to laymen) that psychiatry does have all the answers, an uneasy *mariage de convenance* has been produced that is likely to be with us for some time.

This article is the first in a series of articles on the work of the Forensic Psychiatry Clinic—a large clinic operating under the aegis of the New York City Criminal Court—in evaluating the competency of criminal defendants. The larger issues of the place of psychiatry in the courtroom, the civil rights of criminal offenders, and the overall structure of our national legal-psychiatric-penological establishment are well beyond the scope of

Dr. Goldstein is Medical Director of the Forensic Psychiatry Clinic, New York City Criminal Court, 100 Centre St., New York, N.Y. 10013, and Clinical Instructor in Psychiatry, New York University.

these articles and will be alluded to only when appropriate to the discussion (3–6).

CLINIC PHILOSOPHY CONCERNING COMPETENCY

The Forensic Psychiatry Clinic, since its inception in 1955, has served the New York City Criminal Court in a variety of areas covering several stages of the legal process. The clinic has performed competency screenings and pretrial and presentencing evaluations and has offered recommendations to the court and the office of probation for planning and implementing realistic rehabilitative programs for the mentally ill offender. The clinic staff—psychiatrists, psychologists, and social workers—have all had extensive experience in forensic psychiatry. Staff members come from a variety of training backgrounds and theoretical orientations (e.g., psychoanalysis, behavior therapy, community psychiatry), but all try to steer a steady course between the Scylla of Szaszian iconoclastic doublethink and the Charybdis of the doctrine of parens patriae, which would too eagerly see everyone sent off to the hospital "for treatment." Although proponents of the latter view undoubtedly have the best of intentions, they fail to consider the "unfairness of substituting a benevolent purpose for due process of law where individual liberty is at stake, especially if the benevolent purpose has in reality fallen short of its promise" (7).

The prevailing philosophy of the clinic is that "every man should have his day in court," regardless of whether or not he is mentally ill, provided he is able to satisfy the threefold common law test for competency, which specifies that the defendant: 1) must be capable of understanding the nature and object of the proceedings against him, 2) must be able to comprehend his own condition in relation to such proceedings, and 3) must be able to assist in his defense in a rational or reasonable manner.

We would concur with McGarry, who believes that:

> Unless their criminal charges can be otherwise disposed of, mentally ill defendants are far better served by an expeditious return for trial than by indefinite commitment in a mental hospital while awaiting trial .... Among psychiatrists a bias exists against returning the mentally ill for trial and ... this has led to considerable wasting of human lives and unnecessary deprivations of freedom (8, p. 1181).

We have attempted to avoid such pitfalls by addressing ourselves specifically to the question of competency in its narrowest sense and returning even the seriously disturbed or dangerous individual to face the court if he is competent within the general guidelines of Anglo-Saxon common law.

We have attempted to communicate these objectives to the court, the district attorneys, and the defense counsel. As McGarry has pointed out elsewhere, the confusion and misapprehensions that exist concerning competency, mental illness, and criminal responsibility are not limited to psychiatrists, but unfortunately are shared by experienced judges, lawyers, and laymen (9). The courts have frequently equated the various types of psychiatric examinations, losing sight of the circumscribed focus of the competency evaluation. Evaluation of the defendant's mental state at the time he is to appear for trial is frequently confused with determining his mental state and capacity for responsibility at the time of his offense or with assessing his problems in their entirety, with an eye toward recommending a long-range plan for management or treatment.

TABLE 1

Case Dispositions Following Competency Evaluations in 1969–1970

Disposition	Number of Cases	Percentage of Cases
Evaluated by clinic	1,085	
Competent (returned to court)	608	56.0
Possibly incompetent (referred to hospital)	477	44.0
Found competent at hospital	201	18.5
Committed to state hospital	276	25.4
Total returned to court	809	74.6

CLINIC PROCEDURES BEFORE ENACTMENT OF THE NEW CRIMINAL PROCEDURE LAW

Before enactment of the new Criminal Procedure Law in September 1971, the clinic performed competency screening examinations—brief clinical evaluations to determine, informally, whether the defendant seemed competent. If he seemed competent, he was promptly returned to the court. If there was any doubt about his competency, he was sent to a metropolitan hospital prison psychiatric ward for further observation and examination. Only in the hospital could a formal legal determination of incompetence be made.

The demand for competency screening examinations increased dramatically between 1967 and 1970; 601 examinations were performed in 1967–1968, 837 in 1968–1969, and 1,085 in 1969–1970. The factors contributing to this increase and some of the motives for requesting these examinations were discussed in a previous report from this clinic (10). During each of these years approximately 44 percent of the cases seen for screening were referred to the hospital. This meant that over half of the defendants referred to the clinic were able to return directly to the court to face their charges, without unnecessary interruptions, delays, or interim hospitalization.

Table 1 presents the statistics for the outcome of competency evaluations in 1969–1970, which is representative of the period before enactment of the new Criminal Procedure Law. In this year 42 percent of the defendants who were referred to the hospital were able to return to the court after brief periods of observation and evaluation, as well as some form of therapy in some cases. Thus, only 25.4 percent of the defendants originally referred to the clinic for competency evaluation required

commitment to a state hospital. The remainder of the defendants were returned to the court, through the combined efforts of the clinic and the hospital prison service.

The fact that almost half of the patients sent by the clinic to the hospital for competency evaluation could be returned rather quickly to the court demonstrated the inadequacy of the clinic's screening procedure. Many unnecessary hospitalizations resulted—a sad reflection on psychiatric standards, economic efficiency, and concern for the civil liberties of the patients. Time restrictions and procedural limitations necessitated rapid and sometimes inconclusive evaluations of defendants, with no provision for delay or recall. This often led to the hospitalization of agitated, excited, or confused defendants who were suffering from acute drug or alcohol intoxication, an acute situational reaction, or an acute psychotic episode. When they received some appropriate supportive therapy, these defendants usually reintegrated rather quickly and certainly could have been declared competent by the clinic if we had had the necessary facilities for management and the time for reevaluation.

Cases of malingering and patients with fluctuating paranoid symptomatology, situational reactions of belligerence and negativism, and other equivocal but not unusual clinical states were difficult to evaluate and would probably be sent on to the hospital by cautious and concerned doctors "just to be on the safe side." In a smaller number of cases, misguided therapeutic zeal seemed to be responsible for the referral of an obviously disturbed defendant to the hospital in the hope that the defendant would receive prompt treatment despite his obvious competence. As a rule the hospital would quickly recognize his competence and send him right back.

CHANGES IN CLINIC PROCEDURES AFTER ENACTMENT OF THE NEW LAW

The new Criminal Procedure Law went into effect in New York State on September 1, 1971. The competency issue was covered in Article 730, "Mental Disease or Defect Excluding Fitness to Proceed." The time-honored but frequently misleading terms "competency" and "incompetency" were replaced with new and, one hopes, more precise terminology that differentiates the individual who is "fit to proceed" or has the "capacity to proceed" from the individual who is "unfit" or "incapacitated." The incapacitated individual is defined as one who "as a result of mental disease or defect lacks the capacity to understand the proceedings against him or to assist in his own defense" (1).

The new law provided that competency examinations were henceforth to be performed on a formal basis by the Forensic Psychiatry Clinic. Specific rules and procedures were jointly adopted by the Judicial Conference and the Department of Mental Hygiene. These new procedures and the concomitant expansion of the work load led to a large-scale reassessment of the professional focus and redeployment of manpower within the clinic and to a greater emphasis on the issue of fitness in conferences, seminars, and supervision. The result was the creation of what we wryly refer to as "the fitness factory."

Now each defendant referred for fitness evaluation under a court order is examined by two clinic psychiatrists. In doubtful cases he may be recalled for further examinations. In the interim he is housed in a special section of the jail where doctors, nurses, and paraprofessional workers are available to administer medication and counseling in the atmosphere of a modified therapeutic community. A sufficient amount of time for observation is thus provided to make meaningful, well-substantiated reports to the court. The clinic psychiatrists have the opportunity to discuss and compare their findings, draw upon the testing tools and expertise of the psychologist when necessary,[1] and in most cases confer with the attorneys involved concerning the defendant's ability to effectively assist counsel in planning a rational defense.

The defendant may be found fit by the two psychiatrists and returned to the court or be found unfit and committed by the court to a state mental institution. If the psychiatric examiners are unable to agree, a hearing is scheduled to settle the issue; a hearing may also be scheduled in response to a motion by the court or either attorney.

A review of the clinic's performance from January 1972 through May 1972 will serve to illustrate its role under the new Criminal Procedure Law. During this period 338 subjects were examined for fitness (each by two psychiatrists). Of these, 240 defendants (71 percent) were found fit, which allowed their court action to proceed promptly, and 71 (21 percent) were found unfit and were committed by the court to a state hospital. In the remaining 27 cases (eight percent) a final decision could not be reached by the psychiatrists and, as provided under the new law, the defendants were sent to the prison service of a metropolitan hospital for more prolonged and intensive evaluation of their mental condition. If the hospital prison service is able to return approximately half of these patients to the court, as it has in the past, the population found fit and returned to the court would represent 75 percent of the total.

These figures indicate that under the new system, with the clinic performing fitness examinations on a formal basis, the same percentage of defendant-patients is able to return promptly to the court as under the old system, which used inpatient hospital facilities to perform the bulk of the task. It seems warranted to assume that the clinic's "fitness factory" is able to make dispositions under the provisions of the new law as effectively as were the clinic and hospital together in the past. This means that a substantial burden can be removed from the already overtaxed municipal hospital's prison services and assures that scores of defendants will be spared unnecessary and wasteful hospitalization, transfer back and forth between grim institutions, and additional stigmatization and deprivation of individual freedom before they have

[1] The expanding role of the psychologist in competency determinations will be discussed in a subsequent article.

been convicted of any crime.

There seems to be a fairly consistent proportion (25 percent) of defendants who are found to be unfit or incompetent. The characteristics of this core group need further study and evaluation. At present it seems clear that members of this group can usually be detected by a clinic examination, with minimal need for psychiatric hospitalization to accomplish this objective.

DISCUSSION

Walter Bromberg has stated, "Psychiatrists have been employed as aides to the court in the evaluation of the mental states of accused persons for less than 150 years. In that time they have managed to evoke considerably more discord than have a dozen other types of expert witnesses" (12, p. 1343). Bromberg's article strongly suggested that the optimal utilization of psychiatric knowledge within the legal system is far from being realized. Karl Menninger has asserted that the illegal acts of criminals are the symptoms of mental illness and that the legal acts of the law enforcers are crimes (2). The disconcerting dialectic of Thomas Szasz depicts psychiatrists as ideologists of insanity, manufacturing madness in order to diminish man as a person and oppress him as a citizen (3, 4). In this intellectual climate, it is difficult to leave the lofty debates at the height of Olympus to chip away slowly and tediously at the foot of the mountain of unfinished research. Yet this is what we are attempting to do in our "factory." We are attempting to hone our diagnostic and evaluative tools to their sharpest, to discipline ourselves to focus on the issue of fitness per se, and to return defendants to the court whenever possible. Despite occasional patients with grave and pervasive personality disturbances, most mentally disturbed offenders are fit to participate in the proceedings against them and to make full use of their rights.

Mason (13), Robey (14, 15), and McGarry (8, 9) have helped to clarify the nature and goals of competency examinations under a variety of conditions. Robey's guide to conducting competency evaluations has been an indispensable clinical tool for our staff. Others have designed comprehensive questionnaires and psychological tests and described clinical clues that have seemed less reliable and helpful in dealing with our clinic's population (16–18). In fact, we have found no reliable shortcuts. Each case seems to demand a shrewd clinical appraisal; collateral information gleaned from the attorney, psychologist, previous hospital records, and other sources; and a touch of intuition, guesswork, and just plain luck.

It should be noted that, even after thorough psychiatric scrutiny by a staff closely attuned to the competency issue and strongly favoring the return of the mentally disturbed offender to the court, the percentage of individuals committed as incompetent (25 percent) seems rather high compared with other reports in the literature, which cite figures from 14 percent to as low as four percent in some jurisdictions (8, 17). Whether this is a result of a greater preponderance of severe psychopathology in the population our clinic serves than in that of other jurisdictions,[2] a result of more selective and appropriate referral of defendants for competency evaluation, or a result of other factors has not been established. Amid the complexities of our imperfect legal system and the imperfect science of psychiatry, we can be cheered somewhat by the fact that we are certainly serving the best interests of the mentally ill offender and of justice in the broadest sense when we return the competent defendant promptly to the court.

REFERENCES

1. Simenon G: Maigret Sets a Trap. Harmondsworth, England, Penguin Books, 1968
2. Menninger K: The Crime of Punishment. New York, Viking Press, 1969
3. Szasz TS: Law, Liberty and Psychiatry. New York, Macmillan Co, 1963
4. Szasz TS: Ideology and Insanity. New York, Doubleday & Co, 1970
5. Whitlock FA: Criminal Responsibility and Mental Illness. London, Butterworth & Co, 1963
6. MacDonald JM: Psychiatry and the Criminal. Springfield, Ill, Charles C Thomas, 1969
7. Allington TB: The constitutionality of mandatory commitment following acquittal by reason of insanity. Newsletter of the American Academy of Psychiatry and the Law 3:1–23, 1972
8. McGarry AL: The fate of psychotic offenders returned for trial. Am J Psychiatry 127:1181–1184, 1971
9. McGarry AL: Competency for trial and due process via the state hospital. Am J Psychiatry 122:623–631, 1965
10. Goldman A, Spielmeyer R, Grantz AI: Competency to stand trial: inability to communicate. Read at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3–7, 1971
11. McKinney's Consolidated Laws of New York: Criminal Procedure Law, Book II-A. St Paul, Minn, West Publishing Co, 1970
12. Bromberg W: Psychiatrists in court: the psychiatrist's view. Am J Psychiatry 125:1343–1347, 1969
13. Mason E: Insanity, psychosis and capability. Psychiatric Opinion 3:18–25, 1969
14. Robey A: Criteria for competency to stand trial: a checklist for psychiatrists. Am J Psychiatry 122:616–623, 1965
15. Robey A: Who shall stand trial? Psychiatric Opinion 3:26–31, 1966
16. Bukatman BA, Foy JL, DeGrazia E: What is competency to stand trial? Am J Psychiatry 127:1225–1229, 1971
17. Lipsitt PD, Lelos D, McGarry AL: Competency for trial: a screening instrument. Am J Psychiatry 128:105–109, 1971
18. Marshall MH, Resnik HLP: The diagnostic clue of "hypercompetency." Am J Psychiatry 125:570–572, 1968

[2] The Forensic Psychiatry Clinic of the New York City Criminal Court is responsible for performing competency (fitness) examinations on all defendants who appear before the Manhattan Criminal Court in any case in which the court questions the defendant's competency at any time from arraignment to sentencing. Either the judge or one of the attorneys may raise this question, whereupon the judge issues a court order for an examination.

The number of arraignments made before the Manhattan Criminal Court each year is staggering. In 1967–1968, 110,413 arraignments were handled by the court. A minuscule proportion of these cases (601) were referred for competency screening. In the first five months of 1972—the year this paper was written—38,841 arraignments had been brought before the court and 338 of these cases were referred for competency (now fitness) evaluation—a mere 0.87 percent of the total number of arraignments.

Designing an Experientially Based Continuing Education Program

BY WILLIAM H. BARBER, PH.D., AND HUGH JAMES LURIE, M.D.

Based on their experience in leading continuing education workshops for various mental health workers, the authors recommend the use of experiential learning techniques in such programs to accomplish attitude change, personal involvement, and the development of specific clinical skills. The authors outline elements of design that they feel to be essential to all such training programs, including techniques used in sensitivity groups, and present examples of two possible workshop formats.

EXPERIENTIAL LEARNING METHODS have been increasingly employed to train mental health personnel ever since the beginning of sensitivity training programs in the late 1940s under the auspices of the National Training Laboratories Institute for Applied Behavioral Science (1). Many of these techniques and their uses in particular programs have been described (2), but the precise ways in which attitudinal change is brought about and specific skills are developed in these programs have not been elucidated.

This paper will attempt to describe the aspects of program design that we feel promote: 1) active participation and learning, 2) an examination by participants of their own attitudes toward the material, and 3) achievement of specific behavioral objectives.

BACKGROUND

Increased awareness of mental health problems and of manpower limitations in dealing with them have combined to focus attention on the need for effective preservice and inservice training of personnel in health and mental health fields. This need has led to the development of the Manpower Training Division in the National Institute of Mental Health (3) and to the inauguration of many programs at state and local levels aimed at training mental health workers from many disciplines and retraining existing personnel to help solve mental health problems.

Dr. Barber is Professor, Department of Psychology, Eastern Washington State College, Cheney, Wash. 99004. Dr. Lurie is Coordinator, Continuing Education Program in Psychiatry, Department of Psychiatry, University of Washington School of Medicine, Seattle, Wash.

This work was supported in part by Public Health Service grant MH-11984 from the National Institute of Mental Health.

The authors wish to thank Ms. Margit W. Gerow, University of Washington, for her help.

In such training programs, emphasis is naturally placed on the acquisition of information and a general ability to utilize such information. It has become apparent, however, that attitudinal change and the development of specific mental health skills are equally crucial for the effective training of mental health workers.

PROBLEMS

There are many problems connected with experiential learning. The multiplicity of "experiences" currently available—ranging from nude marathons to highly structured sensitivity sessions or communication workshops—and the many disparate labels and terms that have been attached to particular approaches within the human potential movement make it difficult for anyone but a sophisticated student of the whole movement to distinguish the nuances of similarity or difference among the "schools." Another problem is the lack of specified objectives and predictable outcomes related to particular kinds of group activities. This seems to be due to the relative paucity of validating research (4). In addition, a certain notoriety has become associated with some of the groups within the movement (e.g., nude groups), and this has been accompanied by some suspiciousness and skepticism among the more conservative elements of the mental health community about the movement in general (5).

In planning and implementing courses to increase the expertise of mental health personnel, we believe that we have developed programs that impart information and effect attitude change while also promoting specific interpersonal skills—all in a relatively predictable way. These programs use an experiential learning format that incorporates many of the principles and practices of sensitivity sessions. The elements of design included are felt to lead to attitude change, cognitive awareness, and skill development while also capturing the sense of achievement, closeness, and heightened self-awareness for which the sensitivity groups are, ideally, noted.

CONTEXT AND SETTING

The authors have been associated with workshops in the West (Washington, California, and Oregon) and in the Southeast (Alabama). Participants have included psychiatrists, nonpsychiatric physicians, nurses, doctors' wives, volunteers from mental health agencies, high school and grade school counselors, social workers, and other mental health professionals and paraprofessionals.

The workshops have been organized around varying topics: psychiatry for the nonpsychiatric physician, parent-adolescent relationships, family therapy techniques, seminars on death and dying, and increasing interpersonal skills.

The expectations of the participants in such workshops appear to be varied: some expect a "teacher" to give a didactic, directive presentation of facts; others—those having some experience with new learning models—show interest in experiential techniques as a way of gaining new skills and looking at their own attitudes; and some frankly anticipate being magically "turned on" by a charismatic leader. Participants who approach the workshops with great skepticism or distrust are sometimes unable to unwind, especially during a relatively short session.

For the most part our workshops have been small, with 15 to 40 participants; on one occasion, however, these same techniques were applied to a group of 3,000 participants.

DESIGN OBJECTIVES AND METHODOLOGY

Gibb classified human awareness experiences on a continuum ranging from "personal growth" to "discussion-instructional" (5). The point on this continuum stressed during a particular program will depend not only on the amount of time available (an evening, two days) and the makeup and probable expectations of the group, but also on the subject matter of the workshop. In our workshops we attempted to find positions along this therapeutic-instructional continuum that met specified goals and at the same time provided an opportunity for personal emotional involvement by the participants.

After experimenting with various formats we have isolated several factors that we feel to be crucial in the design of all programs. These include the following:

1. Face validity. Experiential learning exercises must have high face validity; the content of the task must be seen as real by the participants, but not so critical in their lives that the amount of anxiety provoked in discussing the topic cannot easily and quickly be dealt with. The role assumed by the participant must also be actually or potentially vital to either his personal or professional life.

2. Here-and-now focus. Though a workshop topic is usually announced in advance, the primary data used—feelings, attitudes, perceptions—are generated during the session by the participants through their experiences with one another. These data may be examined as subjects in themselves or as they relate to the topic of the workshop.

3. Active involvement. Every participant in a workshop has an active role. This may include an evaluative or observing role, but it is impossible for the participant to avoid being involved in the experience. In this way, some amount of affect is almost invariably mobilized within each participant.

4. Cognitive maps. At the beginning of the workshop a conceptual framework, usually in written form, is provided the participants to help them understand the exercise. This map serves to reduce their anxiety and allows them to evaluate their own performance and their feelings about it during the exercise. Other cognitive maps are developed after the experience, through group discussion and comparison of personal reactions. In this way the experience can be internalized, generalized, and rendered applicable back home.

5. Low ambiguity. Instructions that are clear, simple, and to the point are crucial to the overall success of the program. Emotional and intellectual ambiguity are also minimized by imposition of specific time limits, so that it is always clear that any given exercise is indeed an exercise—to increase personal and professional interpersonal competencies rather than to cope with existential anxiety.

6. Preliminary information. If the objective of the workshop is to develop competencies in dealing with particular clinical issues (such as death or dying, handling a hostile patient, etc.), adequate background information of a specific clinical nature must be provided before each exercise—either in the form of written information, spoken information from the leader, or a provocative videotape. These data keep the focus on the specific issue, allowing participants to examine their own skills, attitudes, and competencies in relation to the issue. The more specific the clinical skill to be scrutinized, the more specific the kind of information that must be provided.

ILLUSTRATIONS

The following examples will attempt to show how learning experiences were designed by us either to develop general interpersonal competence or specific skills and attitudes. For the latter purpose, a much higher degree of structure was imposed on the exercise, and the leader took care to point out the specific clinical relevance of the exercise for participants. For the development of general interviewing skills, less structure was imposed.

A Highly Structured Exercise

A group of approximately 20 physicians, psychiatrists, spouses, and miscellaneous participants met for a weekend workshop devoted to experiential teaching techniques for use with a dying patient. The workshop began with a brief didactic session on death and dying, using the developmental stages of dying patients described by Kübler-Ross (6) as a cognitive base. The workshop participants were then instructed to divide into groups of three, with each member to role-play a doctor, a dying patient, or an observer. After choosing roles the participants were shown a short videotape of a doctor interviewing a dying patient. The doctor tells the patient that he has leukemia, and the patient responds with denial and disbelief. The groups of three were asked to continue the scenario begun on the videotape. The observer was instructed to note the aspects of the interview that appeared to increase the patient's degree of comfort and the parts of the dialogue during which the doctor became uncom-

fortable or anxious and then to evaluate the overall effectiveness of the interview.

After ten minutes the simulated interview was stopped, a few minutes were allowed for feedback from the patient and the observer about the interview, and roles were then reversed, with each member of the trio getting a chance to play a new role. After everyone in each trio had had a chance to play all roles, there was general discussion and a short break. A further segment of the same videotape followed, showing a subsequent stage of the dying patient's course—again followed by role playing, feedback, role change, and general discussion.

This format was used throughout the entire session on death and dying, except for a short period when the group became immobilized by the helpless and hopeless attitude of the patient on the videotape; they were then allowed to see how the physician on the tape did manage to deal with his highly depressed patient.

Feedback about the design of this workshop was in general extremely favorable. Many participants felt that they had learned a great deal about how they came across to their dying patients. Physician participants particularly remarked that when they themselves had to play the dying patient they became more aware of the effect of their interventions.

In this exercise professional roles were clearly delineated, time limitations were definitely imposed so that the participants would not become too uncomfortable in the interviewing experience, and a cognitive framework was provided by use of the Kübler-Ross book and the videotape.

A Less Structured Format

Approximately 30 physicians and nurses, many of whom did not know each other, met for a one-day session designed to improve their basic interpersonal skills in working with patients—generally in office practice.

Part of the workshop was designed to improve general interviewing techniques. The group was divided into subgroups of three; each person in turn took the role of consultee, consultant, and observer. The consultee was asked to share a problem with the consultant—to explain it, answer questions about it, and trust the consultant to understand. The consultant was asked to listen to the consultee, to paraphrase, clarify, and summarize the information he was receiving, and to ask questions that showed his acceptance of the consultee. The observer was requested to be timekeeper, to coordinate role changes, and to take notes during the consultation and at its conclusion share his observations as to what was and what was not helpful about it.

Requirements for this exercise included a fairly strict adherence to time limits, an insistence on the problem being a "real" problem, some preliminary exercises to help the participants feel comfortable in a situation involving personal data, and repeated emphasis by the leader on the universal need for help, so that the exercise would be applicable both for professional roles and in the participant's personal life.

DISCUSSION

Training experiences that have as their objective enabling learners to *do something differently* after the experience require behavioral tryouts, feedback, and "re-try," accompanied by internalization. Some of the elements of design for such experiential programs have been delineated in this paper.

Subjective evaluation of some of the workshops thus structured has yielded interesting observations. Particularly for interprofessional groups and for groups in which there was a high level of anxiety, the elements of design listed above seemed to foster a feeling of closeness among the participants and a sense of mastery that many of them had seldom experienced in a teaching setting. In a significant number of cases participants could view their emotions somewhat objectively as they experienced them; this led to personal insights that could be transferred to professional settings.

We hope that further experimentation with this model and more precise evaluation of its long-term impact on attitude change will lead to successful training programs for professionals and paraprofessionals working in the sensitive field of mental health care.

REFERENCES

1. Bradford WP, Gibb JR, Benne KT (eds): T-Group Theory and Laboratory Method. New York, John Wiley & Sons, 1964
2. Schein EH, Bennis WG: Personal and Organizational Change Through Group Methods: The Laboratory Approach. New York, John Wiley & Sons, 1965
3. Campbell RJ: Psychiatric Education and the Primary Physician, Task Force Report 2. Washington, DC, American Psychiatric Association, 1970
4. Campbell JP, Dunnette MC: Effectiveness of T-group experiences in managerial training and development. Psychol Bull 70:73–104, 1968
5. Gibb JR: Effects of human relations training, in Handbook of Psychotherapy and Behavior Change. Edited by Bergin AE, Garfield SL. New York, John Wiley & Sons, 1970, pp 839–862
6. Kübler-Ross E: On Death and Dying. Riverside, NJ, Macmillan Co, 1970

The Requirements of a Psychiatric Residency Program Circa 1972

BY HARVEY LANGEE, M.D., IRA D. GLICK, M.D., BROWNING HOFFMAN, M.D., LARRY B. SILVER, M.D., AND ANDREW P. MORRISON, M.D.

This paper outlines the consensus of a group of career teachers of psychiatry on the elements of a training program that will produce a professional with competence not only as a physician but in the many other roles a psychiatrist must perform. The group arranged the elements into three headings: what a psychiatric resident needs to know, what he should be able to do, and the characteristics he should develop in the course of his training.

DURING THE FIFTH ANNUAL MEETING of the Association for Academic Psychiatry (AAP), an examination of the programs of psychiatric residency training in the U.S.—their goals, methods, and effectiveness—was begun. The AAP is composed of present and former recipients of the Career Teacher Award of the National Institute of Mental Health. The task of examining the residency programs was of special interest to the AAP since, as career teachers, its members were identified as individuals with a particular interest in and aptitude for the teaching of psychiatry.

The examination was prompted by the career teachers' concern about residency training as a major area of their own responsibility. Some of their questions were: What are the components of a "good" residency program? How can one be more effective as a supervisor? What are the points of view of different training institutions?

Beyond the questions of technique and orientation they saw a number of pressing reasons for a focused examination of residency training. These included the recent dramatic shift in the concept of psychiatric services to the population and the development of other professional and paraprofessional groups with skills previously reserved to the psychiatrist.

There was also an acknowledgment that perhaps residency training primarily for a private practice model of individual psychotherapy may be less than optimum for a profession whose members are increasingly found in salaried positions, in administration, and in teaching and consultative roles. Further, the scope of psychiatric knowledge has broadened substantially in the past decade.

When consideration was given to the requirements of residency training programs, it became apparent that effective examination of such training must begin by examination of the end product. What is a psychiatrist now, and what should he be in the next decade? What are the unique reasons for his existence as a distinct, visible, and highly paid professional?

The task of developing a "job description" of the psychiatrist is complicated by the mystique that is still associated with membership in this profession. This mystique has been dramatized for the public and appears to have been accepted by some psychiatrists and related professionals as well. As a result, certain reactions to the mystique have occurred. The group agreed that a mystique orientation, either pro or con, is more characteristic of professional adolescence than the state of mature wisdom that by now the profession as a whole has achieved.

Of course there are intangibles in the role of the psychiatrist—a role that embodies some of the priestly function found in most societies. This indeed is one element of a job description, but to outline a training program it is necessary to define as precisely as possible all the multiple roles a psychiatrist must fulfill.

The first of these roles is that of a physician, with his ultimate responsibility for life-and-death decisions and his guiding principle of *primum non nocere*. Also, as a physician the psychiatrist is uniquely able when he considers behavior to integrate the whole spectrum of factors influencing the human organism.

The combination of these two unique areas—life-and-death responsibility and wide-spectrum knowledge—should provide a certain affective orientation to other persons. While incapable of precise definition, this orientation should find its expression in a combination of empathy and objectivity in a clinical setting.

Beyond this central role as a physician, there are a number of other roles that would aid in the job description of the psychiatrist:

He is a student of human functioning.

He is a modifier of human behavior and has a variety of methods available for this purpose.

He is an individual with certain personal capacities, among them a tolerance for ambiguity, the ability to forestall premature closure, the ability to maintain simul-

This paper represents a summary of the deliberations of the 25 participants of the fifth annual meeting of the Association for Academic Psychiatry, North Andover, Mass., October 7–9, 1971.

Dr. Langee is Assistant Professor of Psychiatry, University of Florida Medical Center, Gainesville, Fla.; Dr. Glick is Associate Clinical Professor of Psychiatry, University of California, San Francisco, Calif. 94143; Dr. Hoffman is Assistant Professor of Psychiatry and the Law, University of Virginia School of Medicine, Charlottesville, Va.; Dr. Silver is Associate Professor of Psychiatry, Rutgers Medical School, New Brunswick, N.J.; and Dr. Morrison is Assistant Professor of Psychiatry, Tufts-New England Medical Center, Boston, Mass. Address reprint requests to Dr. Glick.

taneous distance and closeness to others, a degree of self-awareness, and, ideally, the capacity for change.

What, then, are the elements of a training program that would produce the professional described above? The career teachers believed that those elements could be arranged into three major headings—what the resident should know, what he should be able to do, and what he should be as a person.

WHAT THE RESIDENT NEEDS TO KNOW

1. The resident should be familiar with many theories of individual psychological personality development so that his knowledge has a broad eclectic base, and he must have an in-depth knowledge of at least one model for clinical application.
2. He should know the biological determinants of behavior and emotion. These would include relevant information from genetics, biochemistry, neurophysiology, neuroanatomy, and medical neurology.
3. He should know how to diagnose patients according to a descriptive nosology and relate this to a theory of psychopathology. To do this he will have to develop observational skills and the ability to use his own feelings as a diagnostic tool.
4. He should know the family, social, and cultural determinants of behavior. He should know how an individual interacts in a one-to-one setting as well as in larger social units. He should know theories of group and family dynamics.
5. He should know how to think critically. He must be able to evaluate the literature and to understand the fundamentals of research methodology.

WHAT THE RESIDENT SHOULD BE ABLE TO DO

1. The resident should be able to use the somatic therapies, including ECT and psychopharmacological agents.
2. He should know how to practice the various psychotherapies. He should be skilled in the forms of individual therapy in current practice that have some validity, and should be able to apply this skill to individuals and also to work with larger social units. Training in individual therapy is essential; training in group therapy, family therapy, and behavior modification is desirable.
3. He should know the concepts and practices of community psychiatry, including consultative techniques and aspects of preventive psychiatry.
4. He should have the tools and motivation for continuing his own education after training.
5. He should be familiar with diagnostic and therapeutic techniques with children and adolescents.

The areas just listed should be covered in the first two years of a residency program. The third year should be elective with opportunities for further training in such areas as teaching; community mental health; child, adolescent, forensic, and administrative psychiatry; research; psychoanalysis; student mental health; psychopharmacology; inpatient care; etc.

THE CHARACTERISTICS HE SHOULD DEVELOP

From this program the resident should be able to develop certain personal and professional characteristics. He should be able to:

1. Tailor the medical model to fit psychiatric objectives. That is, where the medical model tends to deemphasize emotion in the doctor-patient interaction, the psychiatric model encourages the use of emotion for diagnosis and treatment.
2. Accept a variety of values and behaviors in his patients and see them within their own social context.
3. Treat in his own style from a variety of models rather than "pouring into a mold." He should have developed or enhanced his capacity to interact, introspect, reflect, act, and be creative. He should have been able to achieve a change in his own personal growth in the course of his residency. This might have been done through psychotherapy but could also have occurred through supervisory relationships and feedback from other staff.
4. Reaffirm his own dignity as an individual through his training program.

In one sense much of the above can be looked upon as a pious statement akin to being against sin and for motherhood. On the other hand, there is a continuing need to establish the parameters of the psychiatric profession. How does the individual residency program serve present needs? How appropriate are the components of the examinations that lead to Board certification of psychiatrists? It is hoped that the statements herein may provide a basis for discussion of individual residency programs and the relationship of these programs to the task for which training takes place.

The Clinical Case Conference Reconsidered

BY J. REGIS MCNAMARA, PH.D.

The author questions the effectiveness of the case conference, a procedure that is widely used in mental hospitals. He suggests modifications in the conduct of the conference that involve telling the group about the amount of time, effort, and money expended on cases each session. He also proposes an alternative to the case conference that is based on the "critical paths" approach to time and resource management.

INCREASING ATTENTION has been directed toward institutional practices that negatively affect the behavior of the people the institution attempts to serve (1). However, the institutional practices that are a source of concern for the professional staff have been less well studied and understood. One such practice, steeped in the tradition of mental health institutions, is the clinical case conference. Although their exact nature will depend on the specific needs of the institution in which they are held, most case conferences share several common features. First, they are held at fairly regular intervals and are usually attended by a large number of interdisciplinary staff members. Second, the serial presentation of single cases is the focus of concern. Finally, the method of approach involves interdisciplinary data presentation, discussion, and debate followed by diagnostic decision making with or without treatment recommendations.

Although this type of approach has the merit of bringing different points of view to bear on a clinical case, its disadvantages tend to outweigh whatever collective merit the meeting of minds appears to offer. Two of the most outstanding deficiencies noted in this approach are its limited information-cost ratio and its questionable educational value for students and staff alike. Anyone who has ever had to sit through a case conference and listen to what appears to be the never-ending stream of data, debate, and philosophy that is meted out must have thought at one time or another, "What am I doing here?" or "Why should my students have to sit through this?" All too frequently the exchange of ideas about the case turns into a clash of ideas about man and his modus operandi in the world according to Freud, Rogers, or Skinner. Students and staff alike come away from such conferences with their stereotypes of other disciplines all the more reinforced because one discipline failed to recognize the importance of another's "paradigm" in dealing with the case (2). Given this state of affairs, what can be done to improve the nature of the case conference for the individuals involved?

Dr. McNamara is Assistant Professor, Department of Psychology, Ohio University, Athens, Ohio 45701.

ALTERNATIVES

A number of alternatives to the case conference method should be considered, if not actually tried. First, an attempt should be made to make the case conference shorter in length and more problem-oriented. This could be accomplished by means of simple group monitoring and information feedback. In its most elementary form this procedure would involve having the recording secretary start a stopwatch at the beginning of each case and stop it at the point where a collective decision was reached. This information could then be plotted on a graph in the conference room. At the beginning of each subsequent session the chairman could draw attention to the chart on the wall and the length of time the previous session had taken. A variation of this procedure would be to have individual members' contribution times recorded, plotted, and announced in addition to the group times. Both of the aforementioned procedures are predicated on the principle that observation will have a reactive effect on the individuals who are being monitored and will set the occasion for behavior change for these individuals (3).

A more complex way to make individuals aware of the amount of effort continuously being expended on a case would be to have a machine print out the dollars it is costing (prorated on each member's salary) per unit of time that the case conference is in session. After each session these sheets could be posted on the conference room wall and at subsequent sessions the chairman could announce the number of dollars paid to staff members during the previous conference. This is not unrealistic because it has been demonstrated that dysfunctional behavior improves as a result of having monitored records made public and subject to freely occurring environmental consequences (4, 5).

A more drastic way to modify the case conference is to use it in a more adaptive fashion. It is envisioned that a more adaptive case conference could evolve out of new ways by which disciplines relate to one another. For instance, departments could have their own internal organization with regard to both assessment and treatment, with limited extramural contact points between themselves and other departments. In this type of setting, departments that are responsible for assessment and treatment would generate critical intradisciplinary treatment paths according to models now used in business and in-

dustry (6, 7). These treatment paths would be generated independently by psychology, social work, psychiatry, and other disciplines, and would involve the step-by-step charting of the resources and treatment approaches available to that discipline as they are applied in a program of positive behavior change. These charts would then be fed into a computer or be subjected to clerical analysis; mutual collaboration between disciplines would occur only at points where treatment paths intersected with one another.

Intersections might occur under a number of different circumstances. For instance, people from two different disciplines may want to use the same method of treatment with a patient. This situation might occur when psychologists and psychiatrists both want to use electromyogram biofeedback to control muscle tension that the patient has experienced in a certain situation. They would meet and decide which discipline could most effectively administer that form of treatment under the particular circumstances. A different situation might occur if there were an intersection of two or more treatment paths that interfered with one another. If, in a program whose orientation was learning theory, the issue involved drugs and an intersection of treatment pathways occurred, then the psychologist and psychiatrist (one would hope in consultation with a clinical pharmacologist) would meet to resolve only this issue. It is envisioned that if the professional staff adopted such a system they would function at more effective levels both within their own profession and in interdisciplinary endeavors. This is because most of the professional activity in such a system would be directed toward solving problems of a manageable nature instead of reducing dissonance (8) or improving professional perception (9).

Such a system would also provide for program assessment and would allow continuous correction of procedure to increase the discipline's effectiveness in changing behavior. This would follow because once the steps in each critical treatment path for an individual are operationally defined, each health program's efficiency and effectiveness could be easily calculated on the basis of terminal outcome measures of performance (10, 11). "Track records" for each of the disciplines could then be established for different kinds of target problems in different populations. This information could be returned to the system for future reference in resolving interdisciplinary path intersections. An empirical approach like this would certainly be an improvement over the present kind of system, which usually involves little more than resolving superordinate-subordinate power relationships between disciplines.

CONCLUSIONS

The types of recommendations I have made for the case conference are only a few of the possible alternatives that could be used to influence the deeply entrenched organizational behavior of mental health institutions. The best use of the case conference and other institutional practices can be made only if an operations-research model is used in the absence of an empirical support base to test the assumptions and practices that are perpetuated. The case conference, like other behaviors we engage in, may only serve ritualistic needs that are neither functional or necessary for the well-being of staff or patients. We will never know, however, unless the character of the case conference is scrutinized and innovative alternatives are explored.

REFERENCES

1. Goffman E: Asylums. Garden City, NY, Anchor Books, 1961
2. Kuhn TS: The Structure of Scientific Revolutions. Chicago, University of Chicago Press, 1970
3. Patterson GR, Harris A: Some methodological considerations for observation procedures. Read at the annual meeting of the American Psychological Association, San Francisco, Calif, Aug 30–Sept 3, 1968
4. Kanfer FH: Self-monitoring: methodological limitations and clinical applications. J Consult Clin Psychol 35:148–152, 1970
5. Rutner IT, Bugle C: An experimental procedure for the modification of psychotic behavior. J Consult Clin Psychol 33:651–653, 1968
6. Lock D: Scheduling resources by the critical path method. The Director 22:389–394, 1969
7. Lu FPS: The critical path method: what it is, how it's used. Supervisory Management 15:27–31, 1970
8. New PKM: An analysis of the concept of team work. Community Ment Health J 4:326–333, 1968
9. Schacht LS, Blacker M: Leadership effect on the staff conference process. Arch Gen Psychiatry 20:358–364, 1969
10. Deniston OL, Rosenstock IM, Getting VA: Evaluation of program effectiveness. Pub Health Rep 83:323–336, 1968
11. Deniston OL, Rosenstock IM, Welch W, et al: Evaluation of program efficiency. Pub Health Rep 83:603–610, 1968

Rapid Control of Psychotic Excitement States with Intramuscular Haloperidol

BY FRANCINE SANGIOVANNI, M.D., MICHAEL A. TAYLOR, M.D., RICHARD ABRAMS, M.D., AND PEDRO GAZTANAGA, M.D.

The authors conducted an open clinical trial of high doses of parenteral haloperidol in the treatment of 40 acutely excited psychotic inpatients. Their preliminary results suggest that intramuscular haloperidol in doses up to 60 mg. a day is safe, effective, and well tolerated in the management of such patients. Adverse reactions, which were infrequent, included extrapyramidal symptoms, lethargy, and, in one patient, transient hypotension.

THE MANAGEMENT of acutely excited, combative, or agitated psychotic patients on general psychiatric wards is frequently accomplished through the use of parenteral medication. Chlorpromazine is widely used for this purpose, its main limitation being that it sometimes causes hypotension. Oldham and Bott (1) recently found haloperidol (a nonphenothiazine neuroleptic) to be effective and safe in controlling acute excitement states. In view of their results, we undertook an open clinical trial of high-dosage parenteral haloperidol in acutely excited patients.

METHOD

We treated acutely excited patients whose aggressive, overactive, or assaultive behavior could not be controlled by persuasion, seclusion, or parenteral sodium amobarbital (250–500 mg. intramuscularly every four hours). Patients received an initial intramuscular injection of 10 to 30 mg. of haloperidol; the dosage varied with the patient's age, weight, and severity of illness. The dose and frequency of subsequent injections were decided clinically on the basis of the therapeutic response or the development of adverse side effects. Haloperidol injections were given one to three times daily; when adequate behavioral control was achieved, oral medication was instituted.

We evaluated each patient frequently throughout the day for clinical response or for the appearance of unwanted secondary effects. Blood pressure was measured 30 and 60 minutes after the initial injection; a fall in systolic pressure of 20mm.Hg or more below baseline or to a level below 100mm.Hg was recorded as clinically significant. Medication for parkinsonian symptoms was administered when clinically indicated, but never prophylactically.

The authors are with the Department of Psychiatry, New York Medical College-Metropolitan Hospital Center, 1901 First Ave., New York, N.Y. 10029, where Dr. SanGiovanni is a resident, Drs. Taylor and Abrams are Assistant Professors, and Dr. Gaztanaga is a Fellow.

RESULTS

We treated 40 patients, ranging in age from 22 to 69 years (mean = 38 years). There were 22 women and 18 men. Diagnoses included manic-depressive illness, manic type (N = 32); paranoid schizophrenia (N = 2); suspected seizure disorder (N = 3); and organic syndrome (N = 3). The total 24-hour dosage ranged from ten to 60 mg. of haloperidol.

Improvement was rated clinically and categorized as absent, minimal, moderate, or marked (a designation that included complete recovery). As seen in table 1, moderate to marked clinical improvement occurred in 90 percent of the patients within 72 hours. There was no difference between men and women in the eventual control of symptoms (i.e., at the end of 72 hours), but table 2 shows that during the first 24 hours 73 percent of the women responded with moderate or marked improvement, compared with 44 percent of the men ($\chi^2 = 3.29$; $df = 1$; $0.05 < p < 0.10$).

Table 3 shows the total dose of haloperidol required to control the excited behavior (patients who had displayed such behavior showed moderate to marked improvement). Women responded to lower doses of medication than men; 50 percent reached control at a total dose of less than 30 mg., compared with only 17 percent of the men ($\chi^2 = 5.06$; $df = 1$; $p < 0.025$).

Of 18 patients who received an initial injection of 20 to

TABLE 1
Clinical Response to Intramuscular Haloperidol Over 72 Hours

Response	Men		Women		Total	
	Number	Percent	Number	Percent	Number	Percent
Minimal improvement	3	16	1	5	4	10
Moderate improvement	1	6	2	9	3	8
Marked improvement	14	78	19	86	33	82
Total	18		22		40	

TABLE 2
Time Taken to Control Excitement with Intramuscular Haloperidol

Period	Patients Controlled Each 24 Hours (Cumulative)					
	Men		Women		Total	
	Number	Percent	Number	Percent	Number	Percent
24 hours	8	44	16	73	24	60
48 hours	14	78	20	91	34	85
72 hours	15	83	21	95	36	90

30 mg. of haloperidol, 11 showed moderate to marked improvement within 24 hours; all but one were transferred to an oral medication regimen. Of these patients, three had relapses over the second 24-hour period and required an additional day of parenteral medication for a sustained response.

The most frequently encountered side effect was mild to moderate lethargy, which lasted several hours after the injection. This occurred in 35 percent of the patients and almost always during the first day of treatment. A parkinsonian syndrome developed in six patients (four men, two women), each of whom had received medication for more than 24 hours, at a total dose of at least 60 mg. of haloperidol. We also observed that five of these six patients developed this syndrome while receiving injections of haloperidol at the lower single-dose range (15 mg.). The isolated acute dystonic reactions that occurred in four other patients were rapidly relieved by parenteral antiparkinson agents. Coarse hand tremor alone occurred in five additional patients (two men, three women), each receiving 15 mg. injections.

One 27-year-old man had a transient 20 mm.Hg drop in systolic blood pressure after his first 30 mg. injection of haloperidol. There were no observable symptoms from this blood pressure change, and his excitement diminished without the need for further parenteral haloperidol.

TABLE 3
Total Dosage of Intramuscular Haloperidol Required to Control Excitement

Dosage	Men		Women		Total	
	Number	Percent	Number	Percent	Number	Percent
Less than 30 mg.	3	17	11	50	14	35
30–60 mg.	7	39	7	32	14	35
More than 60 mg.	5	28	3	14	8	20
Uncontrolled	3	17	1	5	4	10
Total	18		22		40	

DISCUSSION

Our preliminary results confirm the safety and effectiveness of parenteral haloperidol in daily doses up to 60 mg. for the initial treatment of acutely excited patients. Women appear to respond more rapidly and at lower doses than men, a finding similar to that of Oldham and Bott (1). Ritter and associates (2) recently gave five mg. of haloperidol intramuscularly every six to eight hours and noted moderate to marked improvement in 68 percent of their patients within 48 hours. Our experience suggests that higher dosage haloperidol may yield more rapid and effective control of excitement. This difference may also derive from patient selection, for Ritter and colleagues (2) treated only men.

We observed that the majority of extrapyramidal reactions occurred in patients receiving injections of haloperidol at the lower dosage range (less than 20 mg.); this is consonant with the inverse relation between dosage and extrapyramidal symptoms that has been reported for fluphenazine (3).

We recorded a single episode of hypotension, a low frequency that is similar to the finding of Ritter and associates (2), who found no postural hypotension in their sample, and of Sainsbury (4), who gave as much as 90 mg. of parenteral haloperidol each day to patients with delirium tremens without the development of hypotension. Oldham and Bott (1) reported a somewhat greater incidence of hypotension; four percent of their patients showed a fall in systolic blood pressure below 100 mm. Hg, and 11 percent showed a drop of 20mm.Hg below baseline.

Finally, the nursing staff noted that no patient complained of pain at the injection site, in spite of the large volume of solution (2–4 cc.).

REFERENCES

1. Oldham AJ, Bott M: The management of excitement in a general hospital psychiatric ward by high dosage haloperidol. Acta Psychiatr Scand 47:369–376, 1971
2. Ritter RM, Davidson DE, Robinson TA: Comparison of injectable haloperidol and chlorpromazine. Am J Psychiatry 129:78–81, 1972
3. Rifkin A, Quitkin F, Carillo C, et al: Very high dosage fluphenazine for nonchronic treatment-refractory patients. Arch Gen Psychiatry 25:398–403, 1971
4. Sainsbury P: The management of delirium tremens. Bulletin of Postgraduate Committee in Medicine, University of Sydney 25 (April suppl): 66–77, 1969

Referral Failures: A One-Year Follow-Up

BY WALTER A. CHAMEIDES, M.D., AND JOE YAMAMOTO, M.D.

The authors found that most of the patients in their study—98 out of 153—did not make or keep their appointments at an outpatient clinic after being evaluated and referred. One year later they were able to obtain information on 51 of these patients and found that 40 of them had received some type of professional care.

WHAT HAPPENS to our patients who are referred but fail to follow through with their appointment is an issue that has bothered us at the outpatient clinic of the Los Angeles County-University of Southern California Medical Center. Many of our patients are referred by our psychiatric evaluation-admitting area, which functions as a 24-hour crisis center. This study was an attempt to determine what had happened, after one year, to patients not completing the referral.

Hyman and Schneidman (1) reviewed the records of the 1,265 patients seen in the evaluation area during one month and reported that 153 were referred to the center's outpatient clinic. (The rest were admitted or were referred to other community facilities, or else the crisis was resolved.) These 153 patients were divided into three categories: those who made no contact of any kind to make an appointment (80 patients, or 52 percent); those who phoned for an appointment but never showed up (18 patients, or 12 percent); and those who contacted the clinic and were seen (55 patients, or 36 percent). When they completed their study five months later, 37 of the 55 patients who came for their appointments were still in psychotherapy.

METHOD

The first two categories—the 80 patients who never contacted the clinic and the 18 patients who did but failed to keep their appointments—equal 64 percent of those referred to the center's outpatient clinic. An attempt to determine what happened to them was undertaken a year later, and three methods of information gathering were used. First, we reviewed the patient's chart. If there was no relevant information on the chart, we then telephoned the patient. Finally, if the patient had no phone, we then sent a letter with a questionnaire to be returned. The following are the results of our study one year after referral.

The authors are with the Department of Psychiatry, University of Southern California School of Medicine, 1237 North Mission Rd., Los Angeles, Calif. 90033, where Dr. Chameides is Assistant Clinical Professor and Dr. Yamamoto is Professor.

RESULTS

Of the 80 patients who were referred but did not call for an appointment, we were able to gather information on 38. Our data for these 38 patients were based on 15 hospital charts (three charts were unobtainable), 17 phone contacts (21 had phones), and six questionnaires (41 were mailed). Of these 38 patients, 30 had received some type of care. Fifteen had been in our clinic, nine in other community facilities, and six had been hospitalized. Thus, approximately one year after the original referral, 79 percent of the patients whom we were able to track down had received care.

These patients gave a variety of reasons for not making an appointment. Some denied being told to call; some said that the clinic was too far away; one felt that he got the runaround; one did not call for "fear of being a nut"; others said that they felt better and thus did not need an appointment.

Of the 18 patients who called for an appointment but, after four months, had not arrived, we were able to obtain information on 13. Our data for these 13 patients were based on two hospital records of our clinic patients (one chart was obtainable), six phone contacts (seven had phones), and five questionnaires (nine were mailed). We found that ten patients (77 percent) had received care. Two had been in our clinic, six in other community facilities, and two had been hospitalized.

These patients gave various reasons for not coming to our clinic. There was too long a waiting list; they were feeling better; it was too far to travel; or they did not remember making an appointment. One patient did not come because she discovered that she was pregnant. One stated that she did not keep her appointment because she was in the hospital having a baby at her appointment time. She described the evaluation area as being "like a scene from a 'B' movie . . . long wait . . . a more desperate patient could walk out without anyone helping them. . . . My thoughts may not be too accurate . . . like a bad dream." One patient canceled his apointment because he wanted to try to resolve his crisis on his own.

We also studied the possible effect of the professional role of the therapist who made the initial referral. We found that it made no difference whether the referring professional was a staff psychiatrist, psychiatric resident, or social worker.

In summary, we found that most of the patients in our study—98 out of 153—did not make or keep their ap-

pointments at our clinic after being evaluated and referred. One year later we were able to obtain information on 51 of these patients and found that 40 of them (78 percent) had received some type of professional help.

If we include those 55 patients who made and kept their initial appointments with those receiving professional help after one year, a total of 95 (or 62 percent) of the original 153 referrals received treatment. We were unable to locate 47 of the 153.

DISCUSSION

How are we to evaluate the findings? From our data one could say that continuity of care is not being given to many in this population (2). Another way of looking at these referral failures would be that they were unable to accept the care given to them. Many factors could determine this, including the type of precipitating stress, the social status of the patient, the manner in which patients in crisis are handled, the sex and age of the patient, the time of day patients are seen, and the waiting period for an appointment (3–5). It is of interest to note that Jacobson and associates (6) found that 26 percent of their patients did not return to their crisis treatment center after one visit, even though they were offered further treatment, with no waiting period, by the same therapist. Still, most of the patients whom we were able to locate did get some help during the one-year period. Those requiring hospitalization might be seen as referral failures. However, they may have needed inpatient care from the beginning, and this was accomplished.

One could say that it is reassuring to those of us in the mental health field that referred patients eventually get professional help. It is distressing, however, that our initial encounter with patients in a crisis does not more often lead to a rapid follow-through with resolution of their problems. Finally, it appears that some patients only need to be seen once and to know that help is available.

REFERENCES

1. Hyman M, Schneidman J: The revolving door—a follow-up study of referred patients. Los Angeles, University of Southern California School of Social Work, June 1967 (unpublished master's thesis)
2. Bass RD, Windle C: Continuity of care: an approach to measurement. Am J Psychiatry 129: 196–201, 1972
3. Hollingshead AB, Redlich FC: Social Class and Mental Illness. New York, John Wiley & Sons, 1958
4. Adler LM, Goin M, Yamamoto J: Failed psychiatric clinic appointments—relationship to social class. Calif Med 99: 388–392, 1963
5. Caplan G: Principles of Preventive Psychiatry. New York, Basic Books, 1964
6. Jacobson GF, Wilmer DM, Marley WE, et al: The scope and practice of an early-access brief treatment psychiatric center. Am J Psychiatry 121: 1176–1182, 1965

LETTERS TO THE EDITOR

Rapid Reversal of Tardive Dyskinesia

SIR: The literature on tardive dyskinesia has emphasized the irreversibility of this disorder, which is true in most instances. However, the syndrome may subside in younger individuals and in children (1). In an article published in this journal (2), I indicated that "symptoms . . . may . . . decrease or even disappear after several months off drugs." The case I wish to report here is of interest because tardive dyskinesia subsided in a matter of days after the withdrawal of all neuroleptic agents.

Case 1. Natalie L., a 41-year-old woman, was admitted to Spring Grove State Hospital in July 1972 with a diagnosis of schizophrenia. Although hospitalization was preceded by two and a half years of suspiciousness and withdrawal, she was never hospitalized or treated with psychotropic agents. During the first three or four months of hospitalization, therapy consisted of thiothixene, chlorpromazine, doxepin hydrochloride, and trihexyphenidyl hydrochloride. Although she improved, she continued to experience anxiety and a variety of somatic symptoms.

In November 1972 she was not found ready for discharge and was transferred to my service. When I first saw her, she presented a clinical picture suggestive of akathisia; therefore, the use of all drugs except for anticholinergics was stopped for two weeks. During this period all her symptoms became worse, so I prescribed chlorpromazine in a dosage of 200 to 400 mg. per day. This was later changed to 10 mg. of haloperidol per day, mainly because haloperidol appears to be better tolerated by patients with real or imaginary gastrointestinal disorder.

In April 1973 I suspected that none of the patient's symptoms was drug related; hence, I discontinued trihexyphenidyl hydrochloride. Two days later she complained of dysphagia and dyspnea, but these complaints were not accompanied by objective signs of dystonia. On the other hand, symptoms of parkinsonism were very conspicuous. The administration of haloperidol was discontinued, following which the parkinsonian syndrome cleared completely.

A day or two later, however, she manifested the following symptoms: rhythmical protrusion of the tongue, up-and-down movements of the chin, and mild choreoathetoid activity of the ankles. The clinical characteristics of the new syndrome, its appearance after drug withdrawal, the fact that parkinsonism preceded hypermotility, and finally, the complete absence of discomfort (in a hypochondriacal patient) were consistent with a diagnosis of tardive dyskinesia.

The abnormal motility in the oral region was observed for the first time not only by me, but also by the patient and the nursing personnel. All involuntary movements lasted for about ten days and then subsided, except for an occasional ticlike movement of the lips. Natalie, who was extremely self-conscious about her appearance and eager to report all her ailments in great detail, seemed to be completely unaware of any problem in her mouth or other parts of her body.

The question is, would the patient have developed persistent dyskinesia had I continued the administration of neuroleptics? She improved mentally and went home a few weeks later; I was therefore not confronted with the dilemma of exposing her to further chemotherapy. I feel, however, that patients who are very sensitive to the neurotoxic effects of neuroleptics should not receive such compounds regardless of their mental condition. Too many persons exhibit permanent and often disabling neurological manifestations because these disorders are recognized by accident and the use of neuroleptics is discontinued when it is too late.

REFERENCES

1. McAndrew JB: Effects of prolonged phenothiazine intake on psychotic and other hospitalized children. J Autism Child Schizo 2:75–91, 1972
2. Crane GE: Prevention and management of tardive dyskinesia. Am J Psychiatry 129:466–467, 1972

GEORGE E. CRANE, M.D.
Baltimore, Md.

Intellectual Impairment in Uremic Patients

SIR: The article "The Psychological Evaluation of Patients for a Kidney Transplant and Hemodialysis Program" by Drs. Greenberg, Davis, and Massey (March 1973 issue) leaves several points unclear. The reader is left with the impression that the organic intellectual deficits and decreased energy seen in uremic patients should be taken into account when planning for the instruction of the patient in hemodialysis technique and in planning other areas of the patient's adaptation to the dialysis experience.

Unfortunately, the authors do not mention the point in time during the patient's course when psychological testing was administered, nor do they mention whether testing was repeated after the patient had been adequately dialyzed. One suspects that testing was performed while the patient was uremic, prior to his acceptance into a dialysis-transplant program. These important points should, I believe, be put into proper perspective.

During the past year I have evaluated 18 patients who were accepted for in-center dialysis, and I have had frequent contact with them throughout their subsequent treatment. Together with Greenberg and associates and with Abram (1), I was aware of the "organic" deficits that these patients evidenced while uremic. Prior to dialysis, when the metabolic abnormalities of uremia were flagrant, the patients frequently felt "foggy." They had difficulty with thought, attention, concentration, and memory.

However, the change in mental status following several weeks of adequate dialysis for these patients is considerable. The "organicity" diminishes to a marked degree in almost every case, as measured by bedside mental status evaluations and observations of patients' activities. For the most part, patients are able to learn well (to the extent of returning to college in some cases) and are able to carry out those intellectual functions of which they were capable prior to their periods of severe uremia.

If one of the purposes of psychological assessment is to evaluate a patient's ability to learn dialysis procedures and to help

plan future life activities, these assessments should be made following an adequate initial course of dialysis. If judgments about a patient's intellectual impairment are based solely on assessments performed prior to treatment, these judgments may prematurely label the patient as intellectually impaired. The perceptions of the treating staff may be biased toward viewing the patient as more impaired and less capable of necessary self-responsibility than is actually the case. Since minimization of dependency and maximization of self-care are valued goals in the management of dialysis patients, premature judgments of "organicity" upon which long-term plans are based are to be avoided.

Certainly there is a need for a study in which repeated assessments are made before the relationship between intellectual impairment and chronic dialysis is clear.

REFERENCE

1. Abram HS: The psychiatrist, the treatment of chronic renal failure, and the prolongation of life: II. Am J Psychiatry 126:157–167, 1969

JOEL YAGER, M.D.
Los Angeles, Calif.

SIR: The article by Drs. Greenberg, Davis, and Massey contains some concepts that should not go uncorrected. The authors deal with "organicity" in uremia in terms of "cerebral organic loss" as if it were a fixed quantity somewhat parallel to intellectual impairment in mental deficiency. "Organicity" as seen in uremia refers to acute brain syndrome or delirium. This syndrome, well described by Engel and Romano (1), is one of potential reversibility with change in the state of metabolism of the brain cells. In uremia, because of defective removal of waste products there is interference with the function of these cells. Of paramount importance is the timing of psychological tests of cognitive function in patients with impaired renal function. Testing prior to hemodialysis, i.e., while the patient is uremic, will give entirely different results (poorer function) than testing during or immediately after hemodialysis (better function).

The statement "We found very little evidence of any gross emotional maladjustment in our patient sample" is a conclusion that requires substantiation by data, none of which is given. The experience of most, if not all, clinical investigators in this area makes this statement very much subject to question. In a report in this journal Abram and associates (2) found that the incidence of suicide among hemodialysis patients was between 100 and 400 times greater than that of the general population. In a more recent study by Reichsman and myself (3), which has not been widely read by people who work in the behavioral area because of its publication in a journal of internal medicine, there is a comprehensive report on the problems in the psychological adjustment of these patients. In another investigation that I conducted by nationwide questionnaire of 519 adult hemodialysis patients and transplant recipients (4), the data show a marked deterioration in sexual functioning of hemodialysis patients of both sexes and of male transplant recipients.

There are other problems of importance in the psychological testing of uremic patients that were not described by Drs. Greenberg, Davis, and Massey but which are worthy of mention. If testing is performed prior to making a firm commitment to the patient that he will be accepted into a program of treatment, it will tend to be seen by the patient as a means of evaluation to determine whether he lives or dies, whether he will be accepted or rejected. This is a factor that must affect the test results.

Lastly, these patients are often quite sick and therefore unable to engage in concentrated activity over a long period of time. The statement that "a large number of patients are not prepared for the fact that the testing will last a number of hours and will require their cooperation" is best responded to by saying that these patients should not be tested for a number of hours. Testing should be performed over a much shorter period of time.

REFERENCES

1. Engel GL, Romano J: Delirium: a syndrome of cerebral insufficiency. J Chronic Dis 9:260–277, 1959
2. Abram HS, Moore GL, Westervelt FB Jr: Suicidal behavior in chronic dialysis patients. Am J Psychiatry 127:1199–1204, 1971
3. Reichsman F, Levy NB: Problems in adaptation to maintenance hemodialysis: a four-year study of 25 patients. Arch Intern Med 130:859–865, 1972
4. Levy NB: Sexual adjustment to maintenance hemodialysis and renal transplantation: national survey by questionnaire: preliminary report. Trans Am Soc Artif Intern Organs 19:138–143, 1973

NORMAN B. LEVY, M.D.
Brooklyn, N.Y.

Drs. Greenberg, Davis, and Massey Reply

SIR: We would like to thank Drs. Yager and Levy for their thoughtful comments and the chance it gives us to further clarify our paper. Basically the comments revolve about the issues of potential intellectual deficits and serious psychological disturbances in hemodialysis and kidney transplant candidates.

We are in agreement with the fact that the mental status of these patients appears most consistent with the hypothesis of organicity when the patients are uremic. For this reason the patients in our sample who required dialysis at the time of evaluation were tested as soon after they were dialyzed as possible. Every effort was made to ensure that we were seeing the patients in as nonuremic a state as possible. We were interested in obtaining data under optimal physical conditions. Further, although some of the patients required hours of evaluation, the evaluations were conducted during more than one session to minimize the effects of fatigue and prolonged activities. Nonetheless, as we noted, almost all of our patients exhibited behaviors consistent with some type of intellectual deficit. This does not mean that our patients as a group looked markedly organic; they did not. Further, our paper raised the possibility that the losses might be reversible.

We would conclude from the data that *most* of our candidates exhibited deficit to some degree and therefore indications of minimal deficit should not be interpreted as unusual or used as a differentiating negative sign in making prognostic judgments concerning future adaptation.

With regard to personality evaluation, our sample of patients did not show evidences of severe psychopathology. No clinical or psychological test indicators (e.g., Rorschach genetic levels, F + percent, and R + percent [1]) gave significant evidence of severe disturbance. As we stated, none of our candidates exhibited delusions, hallucinations, or thought disorders. None were judged to be schizophrenic or psychotic although they were certainly defensive and had difficulty modulating affect. We did not consider our patients to be demonstrating severe psychopathology because they were having some difficulty adjusting to a life-threatening situation.

Abram and associates (2) did indeed find in their survey that the incidence of suicide is significantly higher in hemodialysis

patients than in the population at large. They reported a one-percent incidence of clear suicide attempts in this population, which is about 100 times greater than that of the general population. Put in other terms, if you interviewed 100 hemodialysis patients you might expect one to be clearly suicidal. We conclude that although the incidence is higher in this group, suicidal behavior is still not "typical" of the average hemodialysis patient.

The survey of Abram and associates also concluded that approximately three percent of dialysis patients die as a result of not rigidly adhering to treatment regimen. Goldstein and Reznikoff (3) argued that this behavior should not be considered "suicidal." They demonstrated the tendency of the dialysis patient to adopt an external locus of control with the result that patients do not perceive their behavior as playing much of a role in what happens to them. Thus they tend to perceive following their regimen as not particularly relevant to treatment outcome. Relatedly, we stressed that appropriate preparation and referral information might be therapeutic in giving the patient the feeling that he too is playing an important and active part in the treatment process.

In sum, we must still conclude that although there are certainly indications of adaptational difficulties, the "typical" patient we observed did not break down as a result of the stress. This finding is consistent with Sand, Livingston, and Wright's finding (4) that their sample was free from "gross psychological disturbances" and Abram's statement (5) that "the patient's ability to adapt to and function in the near terminal stages of uremia is seemingly better than previously recognized."

REFERENCES

1. Goldfried M, Stricker R, Weiner IB: Rorschach Handbook of Clinical and Research Applications. Englewood Cliffs, NJ, Prentice-Hall, 1971
2. Abram HS, Moore GL, Westervelt FB Jr: Suicidal behavior in chronic dialysis patients. Am J Psychiatry 127:1199–1204, 1971
3. Goldstein AM, Reznikoff M: Suicide in chronic hemodialysis patients from an external locus of control framework. Am J Psychiatry 127:1204–1207, 1971
4. Sand P, Livingston G, Wright RG: Psychological assessment of candidates for a hemodialysis program. Ann Intern Med 64:602–610, 1966
5. Abram HS: The psychiatrist, the treatment of chronic renal failure, and the prolongation of life: II. Am J Psychiatry 126:157–167, 1969

ROGER P. GREENBERG, PH.D.
GARY DAVIS, PH.D.
RONALD MASSEY, PH.D.
Syracuse, N.Y.

Assessing Self-Assessment

SIR: As a practicing psychiatrist I share the concern of my colleagues for maintaining high professional and ethical standards. However, the "Questions of the Month" from APA's Self-Assessment Program published in your December 1972 issue represent another area of concern.

How do you test a psychiatrist's proficiency to treat patients? Surely the knowledge required to answer the two published questions correctly does *not* in any way indicate the doctor's skills as a therapist. In fact, I would question the judgment of a committee that would include these two questions in a psychiatric self-evaluation test. I would be interested in knowing whether this feeling is shared by a significant number of other psychiatrists.

MARIAN G. MALCOLM, M.D.
Tenafly, N.J.

SIR: This letter is in answer to a letter from President Talkington in January 1973 strongly requesting that I take a self-assessment examination in order to avoid unpleasant situations with the U.S. government and the American Psychiatric Association.

When I received the Association's first request for self-assessment my reaction was to wonder whether or not the persons making up the examinations would know the right questions to ask me. For example, how are they going to test me for general clinical ability and aptitude? Numerous papers have revealed that persons with certain aptitudes for dealing with emotional illnesses have better results than others, regardless of what their training might be. Since medicine is a mixture of alchemy and magic that results in what we speak of as "the art of medicine," I wonder how they are going to test my possession of that mysterious art.

I recently wrote a textbook on psychiatry (1) that is widely used today in the psychology departments of various colleges. In order to write this book I had to learn a great deal about computers. I wonder how many test questions in the Self-Assessment Program deal with computers and if the men making up the test really know what a ToTe computer is. How many questions would they be able to ask me about it?

I wonder how many questions in the Self-Assessment Program will deal with the field of cerebral allergies, which is a specialty that has interested me a great deal. In fact, I find it so important that I test all my patients for food allergies. One of my patients is sensitive to chocolate and sugar. He recently ate a candy bar and came into my office psychotic for the first time in many months. I wonder if the Self-Assessment Program will ask me how such a reaction should be treated.

I have also discovered that one-third of my patients have low serum B-12 levels. I wonder how many of the questions of the Self-Assessment Program will deal with the metabolism of vitamin B-12. For instance, where exactly is it used as a coenzyme and what are the neurological effects of its absence? Is the lack of vitamin B-12 best treated by injections of cyanocobalamin or hydroxycobalamin, or are the results better when these are combined with crude liver extract injections? Also, what about folic acid levels in these patients, how should serum folic deficiencies best be treated, and do these have an effect on the central nervous system?

Will the Self-Assessment Program ask how many physicians have their patients examined yearly to assess their body levels of such important minerals as calcium, magnesium, and zinc, all of which are intimately connected with neurochemical processes?

Perhaps most important of all, I wonder how the Self-Assessment Program will test my creativity and the creativity of the members of the American Psychiatric Association. American psychiatry is singularly lacking in creativity. There is much rehashing of old stews but the fact is that psychoanalysis, electroconvulsive therapy, and the use of tranquilizers have all been imported from Europe. I wonder whether an attempt will be made to correct this lack in the members or whether those members without creativity will simply be dismissed from the Association. I wonder if continuing self-assessment and relicensing procedures will attract creative people to our profession

or simply nauseate them and turn them toward other professions.

Lastly, I wonder how the assessors are going to test me for my ability to write. I spent a year at the New School for Social Research taking writing courses that I find very valuable, but I wonder exactly how much the assessors know about the techniques of creative writing.

It would seem to me that the American Psychiatric Association should spend its money fighting any legislative proposals for recertification rather than meekly going along with this bureaucratic trend and even assisting it. I suspect that the assessors are simply uncreative bureaucrats who secretly want to turn APA into one big Boy Scout troop whose members bathe every day and help old ladies across streets, receiving Brownie points for their good deeds.

Forgive me for sounding emotional. I do not ordinarily write letters such as this, especially since I am in the midst of another book and am up at 6:30 every morning to work on it. The problem is that the letter from Dr. Talkington was so repulsive to me that it was necessary for me to get my feelings off my chest.

I take it that psychologists, marriage counselors, gurus, self-appointed encounter group leaders, ministers, the neighborhood bartender, and all the other people who deal with psychiatric problems will also be examined and will receive certificates telling how many Brownie points they have been given throughout the year.

REFERENCE

1. Newbold HL: The Psychiatric Programming of People: Neo-Behavioral Orthomolecular Psychiatry. New York, Pergamon Press, 1972

H. L. NEWBOLD, M.D.
New York, N.Y.

Dr. Carmichael Replies

SIR: Drs. Malcolm and Newbold base their objections to APA's Self-Assessment Program on what it has never professed to do. It was never intended, nor could it have even been conceived, that the program would effectively measure every aspect of a practicing psychiatrist's knowledge and skills. Could any program on any subject, medical or nonmedical, possibly test the universe of knowledge about *any* field?

What the program *does* profess to do is provide a reasonably accurate measure of the degree to which a practicing psychiatrist has retained knowledge of basic facts and skills in procedures he was once taught. In that respect, it serves an important function. Dr. Malcolm is correct in pointing out that individual skill in treating patients is not measurable. But we have not attempted to do that. Likewise, Dr. Newbold may well wonder whether the framers of the test will include questions about B-12 metabolism, but to include questions relevant to the special interests of every member of the Association is simply beyond comprehension.

In sum, then, I must reject these complaints as basically groundless. Let these physicians focus instead on whatever shortcomings they find in the Self-Assessment Program itself—not on how it fails to measure up to admittedly impossible comprehensiveness.

HUGH T. CARMICHAEL, M.D.
Director, APA Office of Continuing Education for Psychiatrists
Washington, D.C.

Ataractic Drugs Versus ECT in Schizophrenia

SIR: In my opinion, Drs. Murillo and Exner, in their article "The Effects of Regressive ECT with Process Schizophrenics" (March 1973 issue), seriously compromise their findings by methodologic errors.

The area of greatest concern is their lack of specificity in reporting the drug therapy of their control group. They fail to specify the type and dosages of the ataractic drugs used. In my own experience and that of my colleagues at the Sacramento Medical Center, dosage is a critical factor; many schizophrenics do not respond to the usual recommended dosages.

In addition, we have been struck by the difference in response between the sedative and the nonsedative antipsychotic drugs. Nonsedative antipsychotics, in our opinion, lead to more prompt and complete remission of psychotic symptoms. Thus Drs. Murillo and Exner could indeed show that regressive ECT led to a more favorable response if they selected their ataractic drugs poorly and used them in small dosages.

JAMES SPENSLEY, M.D.
Sacramento, Calif.

Drs. Murillo and Exner Reply

SIR: In Dr. Spensley's communication there appear to be three issues, explicit or implicit, that require some comment. First, Dr. Spensley is quite correct in noting our failure to include the types of drugs used with our control group. Our own volume of correspondence points to the significance of this omission, which occurred primarily because of space limitations. Three different drugs were used with our controls: 11 patients received haloperidol (Haldol), six were treated with chlorpromazine (Thorazine), and four received a combination of trifluoperazine hydrochloride (Stelazine) and chlorpromazine. The selection of which drug should be used was left to the psychiatrist responsible for the individual patient.

The second issue raised by Dr. Spensley concerns dosage. As in the selection of drugs, the psychiatrist responsible for the patient made the decisions concerning dosage. In general, dosages were at, or higher than, recommended levels. Our decision to follow this procedure was based on two factors. First, we were not interested in testing for the effects of one single drug or specific dosage level. Rather, we were interested that our control group be treated under natural conditions wherein good medical judgment was displayed. Second, none of the five attending psychiatrists knew which patients were actually included in our study; data were collected on all of the patients in the hospital. To have interfered with the normal hospital routine could have "blown our cover" and our subjects might have been treated somehow differently than were other patients.

Finally, and possibly most important, is Dr. Spensley's implication that the patients treated with drugs did not improve. This is simply not true. All 21 of the controls manifested complete remission and were discharged from the hospital. The fact that the patients treated with regressive ECT were rated more favorably at discharge and seven to nine weeks thereafter does not mean that those treated with drugs were not "successful" cases. We are currently in the third year of an extensive follow-up of these subjects and find that the majority in each group continue to sustain the treatment gains. The relapse rate in each group has been low, and the behavioral ratings obtained have been generally quite reassuring.

We do not wish to imply by our data that regressive ECT

should now replace chemotherapy as *the* treatment for process schizophrenia, for that is clearly not a warranted conclusion. We do believe, however, that our work calls attention to another viable treatment modality that can be effective for some schizophrenic patients.

There obviously remain many unanswered questions about the how and why of regressive ECT. In fact, the mysteries of convulsive treatment plague us now as much as they have others in past decades. We feel that the potentials of the treatment method are quite favorable. However, substantially more investigation into the effects of the treatment—especially using some of the more sophisticated methods of neurology and biochemistry—as well as additional studies such as ours concerning the outcome of the treatment are required before definitive conclusions may be drawn.

LUIS G. MURILLO, M.D.
JOHN E. EXNER, JR., PH.D.
Ossining-on-Hudson, N.Y.

No-Suicide Decisions: A Procedural Rule

SIR: The results reported with suicidal patients by Drs. Drye and Goulding and Ms. Goulding in "No-Suicide Decisions: Patient Monitoring of Suicidal Risk" (February 1973 issue) are impressive. This important contribution was nevertheless difficult to read; I had to keep rereading and referring back to clarify the procedures. This difficulty was partly a result of writing style and, more importantly, of the sequence of steps described.

Because the procedure looks as if it could be taught to various staff members in a reasonably reliable and effective way, I have devised a graphic "flow chart" that is actually an algorithm (procedural rule) allowing correct step-by-step decisions, even if one's memory is not perfect. Although it is impossible to reproduce the chart in this section of the *Journal*, copies of it are available from me on request at the address below.

I would like to recommend that more therapeutic procedures be presented in the form of a flow chart; it is a great help in developing the logic of a proposal. Why couldn't our income tax forms be set up in this way?

Incidentally, the authors of the article under discussion seem to use a transactional or decision-making orientation. Their procedure can also be understood as the gradual shaping of verbal and covert responses that seem to be incompatible with overt self-destructive behavior. A number of possible additional steps might be considered, such as gradually lengthening the time span of the decision.

ROSS GRUMET, M.D.
Director of Training and Research
Georgia Regional Hospital at Atlanta
3073 Panthersville Rd.
Decatur, Ga. 30034

Dr. Drye Replies

SIR: I think Dr. Grumet's suggestion of a flow sheet is interesting and potentially helpful. The flow sheet could have a variety of designs, as long as the arrows eventually get back to one of three points: 1) "I will not kill myself, no matter what, for a definite period of time." This is the safe position. 2) "I won't make such a statement." Patient requires supervision. 3) "I won't kill myself, if . . . ." This is a qualified position and further work is needed to reach point 1 or 2. As Dr. Grumet suggests, the time span portion is the easiest to work with and can be gradually lengthened.

This is certainly a transactional model, with a strong emphasis on the ability of both patient and evaluator to reach clear decisions. In this procedure, when the patient reaches conclusions incompatible with suicide, at least for a period of time, he may be considered safe for that period. I want to thank Dr. Grumet for his perceptive comments and suggestions.

ROBERT C. DRYE, M.D.
Carmel, Calif.

Broken Promises

SIR: Consider the following events. Between September 1971 and June 1973, a single U.S. Army installation lost four assigned psychiatrists to conscientious objection. All had been deferred under Berry Plan agreements and all declared conscientious objector status immediately prior to their conclusion of residency training and commencement of active duty.

While conscientious objection and changes in one's personal beliefs are acceptable, it would be a most curious coincidence that four men of the same medical specialty, bound by the same contract, should declare the same personal-legal status at identical times in their lives. That this should have occurred at a single location strongly suggests that this phenomenon is widespread.

In addition, I have been informed that recently several Berry Plan-deferred physicians successfully brought suit to avoid military service by alleging that their contracts constituted "forced enlistment" and were therefore not binding. Apparently, their feeling was that since the draft is now no longer operative, physicians should be exempt, despite the fact that they avoided active duty previously by promising to serve at the present time.

Indeed, it is difficult to imagine anyone entering a Berry Plan contract except to avoid being drafted as a generalist or at a risky period of time in one's career. Further, it has become a common belief that declaration as a conscientious objector is likely to be successful simply if one is a physician. The military appears to have been complicit in this by not contesting such cases.

I am by no means promoting military service for psychiatrists. The practice of third-rate medicine in the military is usually a frustrating, demoralizing, and unpleasant experience. What alarms me is the apparent facility with which a seemingly sizable number of psychiatrists are able to consider a contractual agreement void for reasons of personal convenience. It is difficult to interpret the above data otherwise. I hope this is not indicative of a general drift toward a lack of integrity within the profession.

JON BETWEE, M.D.
Rochester, N.Y.

BOOK REVIEWS

Psychiatry and Ethics, *by Maurice Levine, M.D. New York, George Braziller, 1972, 377 pages, $12.50.*

This is the second book and the posthumously published work of a dedicated, scholarly, respected, and warmly human colleague. Maury Levine was a man of the greatest personal and professional integrity, and his choice of the area of ethics in its broader aspects is most appropriate. His thoughtful and carefully written study following 40 years of work as a psychiatrist warrants the scrutiny of all in our field.

Part 1 includes ten succinct chapters concerning psychiatry and ethics, which the author developed from a series of six lectures given upon invitation from the Weil Institute in Cincinnati. Part 2 includes six selected papers by the author, plus ample notes and bibliography. There is an excellent introduction by Margaret Mead and a fine biographical note on the author by George L. Engel.

This book is *not* a study of the ethics of psychiatry or of its practitioners in their many avenues of professional activity. In some contrast, it presents a broad sampling of the ways in which psychiatry and related fields can contribute to the further development of ethical principles and ethical behavior. The value of a multidisciplinary approach to the constructive evolvement of ethics becomes increasingly evident.

The discussion of ethics, even in a broad context and in a psychiatric setting, could well become involved, pedantic, and/or dull. However, this is far from the case here. The author's approach is subtly easy and conversational in tone. Indeed, his style is almost deceptively simple, and the book's thought-provoking content seems at first misleadingly easy to absorb.

Noting that "a good part of a man's ethics consists of the ways in which he copes with his temptations," Levine opens by discussing the process of self-scrutiny, with its attendant hazards, pitfalls, and temptations, personally illustrating important points. The ethical parts of the personality are likely to be regarded approvingly and as positive, in contrast with certain hostile and sexual aspects.

According to Levine, the concept of a working alliance (as in the therapeutic situation) is of great importance in the development of ethical principles and behavior. In the pursuit of such developments and for the overall study, he defines ethics as referring to those patterns of individuals or groups that are relatively restrictive, limiting, or inhibiting of otherwise destructive impulses or behavior. He also uses the term to refer to patterns that foster the growth of constructive and creative impulses and behavior. Ethical values vary culturally, historically, and individually according to age and maturity, and also psychodynamically.

The author discusses how ethics enters into survival, as man's scientific and technological advances have multiplied at a dizzying pace. Complexities increase, and greater dangers to man are inherent. Advances in our understanding of man and "an ongoing development of an ethics in contemporary terms" accordingly become essential in order to keep pace and to thereby reduce the accompanying hazards to survival.

According to Levine, the most constructive type of thinking is dynamic, realistic, and integrative. It is necessary to the study and understanding of emotional conflicts and psychodynamics. Dependency is a significant source for early conflicts, as are hostile and sexual urges. Ethics involves the interplay, conflict, and relative harmony of the various forces that are inside the human animal. Indeed, the direct study of man reveals the primary importance of intrapsychic conflict. The author outlines and tabulates defenses, defensive ethics, and creative ethics.

Levine presents a beautiful discussion of the therapeutic alliance, carefully noting and illustrating many facets in its function, development, and operation. It is an experience in partnership. Its optimal operation contributes a basic and essential framework for the resolution of emotional conflict, the fostering of understanding, and the further development and maturation of individual ethical principles.

Contributions from psychiatry to the understanding and further development of ethical principles and behavior for both the individual and group are prominent in the major subareas of psychodynamics, personality development, psychopathology, psychotherapy, and psychoanalysis. In the study of man, especially from the ethical standpoint, a major emphasis is on the relationship and conflicts among the various forces inside him, with a secondary emphasis on his relationships and conflicts with the forces outside himself. The resolution of conflicts, in part at least, is the central issue of ethics.

I find it challenging and difficult to choose a few cogent samples from Maury Levine's fine and careful exposition that will do it justice for the prospective reader. But let me cite his call for three types of ego patterns that can be usefully so categorized and perhaps protectively elaborated in the further development of constructive or creative patterns of ethics. They are the stringent self-scrutiny of one's conscience, the stringent scrutiny of external standards, and the development of a strong ego pattern of cross-validation of internal standards by external standards, and vice versa. A comparable scrutiny by the group in turn is also essential.

I recommend this book without qualification. It is a fine contribution to the field and will be useful to psychiatrists and those in allied disciplines alike.

These are days of a rising tide of professional conscience and self-examination, accompanied by an approaching wave of government-sponsored peer review. At the initiation of this epoch this study is especially appropriate and timely.

HENRY P. LAUGHLIN, M.D.
Bethesda, Md.

Drug Use in America: Problems in Perspective. Second Report of the National Commission on Marihuana and Drug Abuse. *Washington, D.C., U.S. Government Printing Office, 1973, 481 pp., $2.60 (paper).*

Should one at first glance be inclined to pass over this volume and think it to be simply another drug report, that would prove to be a mistake, for the volume turns out to be a carefully considered, well-reasoned, authoritative examination of the drug

problem in America as seen in broad perspective. The commission reporting was a blue-ribbon group and had full authority and plentiful resources, and it used them both wisely and well. Composed of senators, educators, psychiatrists, and others, all of them outstanding, the commission read widely, heard numerous witnesses, and traveled through 36 nations in order to investigate firsthand the various facets of the drug problem.

After describing the phenomena of drug use, drug-induced behavior, and drug dependence, the report presents, among other things, a process for assessing the social impact of the problem. It notes that regardless of the country involved, there are common threads to be found that relate the concerns of various nations about the same subject. Our own nation, therefore, is not the only one currently exercised about the drug picture.

The first step toward resolving the drug problem, the panel states, should be a reconsideration of the present diagnosis of the ailment, for the present social response is a large part of the problem, and it is compounded by each unanticipated crisis. Preoccupation with the drugs must be replaced by an understanding of the behavioral impact of their use. The group then does its best to construct a coherent policy that, despite legitimate criticism, it believes should have a beneficial impact; and one can agree that it should. It warns that promises which cannot be kept must not be made. Disapproval of drug use is a part of a larger social pattern, and all the money and effort that American society can muster will never be able to deal effectively with this behavior if the problem continues to be defined as it is now. This statement should be sobering to the varied groups of experts who presently are ubiquitous and vocal and are holding forth, each sure that it has all the answers.

En route and as a small part of its examination, the commission notes the widespread use of alcohol and cigarettes in the general population. Although the vast majority of people do not regard either alcohol or tobacco as drugs, the panel notes that a significant relationship is found to exist between them and the use of drug substances. "While the use of alcohol and tobacco cannot be said to lead to other types of drug use, this behavior can be viewed as a precursor to, and a fairly accurate predictor of, other types of drug using behavior" (p. 45).

It would be unfair and injudicious for a reviewer to pick out various and sundry segments from the text of the report for comment, for the volume is packed with information on all aspects of the complicated picture, which now occupies the attention of the country at large. All angles of the situation are considered, and the panel seems to have missed nothing that might contribute to the solution of the present pressing national concern.

One frequently hears of the success of the so-called British system of heroin maintenance. In some quarters it is being strongly advocated, and suggestions are made that we follow it in the United States. The commission carefully examined that system and reports that "the individual and social benefits offered by Heroin Maintenance are insufficient under current conditions to outweigh its therapeutic disadvantages, and the risk of increased dependence." Adoption of the system at the present time, it believes, would be an irreversible act.

It is difficult to convey in a brief review the wide range of the investigation that this group undertook. Chapter 5 of its report, titled "Looking Ahead," is particularly important. It summarizes the objectives of the commission and sets forth its opinions about what might be done in the immediate future. It recognizes that policy makers must periodically rethink the basic issues and overhaul their responses. The panel believes that in four years the measures that they have recommended will have had time for a full trial. If they have failed, or even if they have only partially succeeded, a second complete evaluation will be necessary.

Thus, despite its thoroughness, the commission realizes that there are some questions not yet answered, and it frankly admits that only time and experience will show whether its recommendations are realistic.

In my opinion this is the best overall survey of the drug scene yet to appear. The book is particularly well written; it is free of jargon; and everyone who is interested in the drug problem as seen in broad perspective will be repaid amply by reading it.

F.J.B.

Alcohol and Health. Report from the Secretary of Health, Education, and Welfare. *New York, Charles Scribner's Sons, 1973, 360 pp., $3.95 (paper).*

This paperback report by a special task force chaired by Morris Chafetz, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism, is to the Congress of the United States. It was mandated by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, through Elliot Richardson, then Secretary of Health, Education, and Welfare. The report gives a broad but detailed account of this nation's most tragic, destructive, and costly public health problem. Alcohol abuse and alcoholism affect about nine million men and women in the United States, play a major role in half our highway fatalities, drain our economy of an estimated $15 billion a year, and account for 40 to 49 percent of all arrests.

This report brings together a substantial portion of the current scientific knowledge on the consequences to health of using, and especially of abusing, alcoholic beverages. The information is presented in language understandable to the layman as well as to the professional. A perspective of the history and epidemiology of alcohol use and abuse is given. In general, men drink three times as much as women, and alcoholic persons drink 11 times as much as others. Of 20 countries surveyed, the per-capita consumption of alcohol was highest in France, with Italy a close second and the United States seventh. Among American Indians the rate of alcoholism is as high as 25 to 50 percent. About one alcoholic out of six is a woman.

The effect of alcohol on the central nervous system as well as on other body organs and tissues is discussed. Alcohol-related illnesses are numerous and often severe. Causal theories of alcoholism include genetic, physiological, pharmacological, psychological, social, cultural, and deviant behavioral learning, all of which may contribute to a particular individual's addiction. This report presents the various and numerous modalities of treatment available but rightly stresses the need for individualization of treatment to fit the unique needs of the particular patient.

The legal status of alcoholism and intoxication in various states is discussed in detail and a plea made for treatment, rather than criminal punishment, while protecting at the same time the public safety. An appendix gives the particulars of the federally sponsored uniform Alcoholism and Intoxication Treatment Act as a guideline for state legislation.

Finally, this report outlines the need for applied research and the direction that it might take. The area of biomedical factors and cross-tolerances is mentioned along with more meaningful distinctions between alcoholic persons and individually suitable forms of treatment. The National Institute on Alcohol Abuse and Alcoholism will emphasize behavioral

science research toward better control, treatment, and prevention of alcoholism and alcohol-related problems.

FREDERICK LEMERE, M.D.
Seattle, Wash.

Evaluation and Management of the Violent Patient: Guidelines in the Hospital and Institution, *by John R. Lion, M.D. Springfield, Ill., Charles C Thomas, 1972, 74 pp., $6.*

More young psychiatrists should write books like this. Aimed at the beginning psychiatrist, it is neat yet inclusive and suitable for the older man and his continuing education. It tells what to say in a way that hearkens back to the real-life style of Carl Rogers' *Counseling and Psychotherapy* (1). In addition, it sets out the doctor's role with the violent patient, i.e., more medical doctor than psychiatrist and a teacher helping the patient to cope with inner helplessness and educating him to verbalize, to fantasize, and to recognize warning signs.

Violence is found in a large group of patients and is one of the problems that psychiatry can no longer avoid, especially with the courts and others demanding more public services. Thus it is timely to have this straightforward advice on how to comport oneself with the violent patient, how to manage feelings of staff and security officers, what to ask about weapons, and how to deal with (surviving) victims. Other matters, such as prediction of violence and making a show of force, are not indexed, but helpful hints are included all the same.

The book deals with adolescents as well as with older patients and should be useful in general hospital emergency rooms, outpatient settings, and most psychiatric inpatient services, including the alcoholism and adolescent wards of large hospitals. The chapter on treatment is particularly useful and should interest even those bound for the private office.

Most chapters conclude with choice, easily available references, including works by the author. The book ends with eight case examples and a resultant conclusion.

REFERENCE

1. Rogers CR: Counseling and Psychotherapy. Boston, Houghton Mifflin, 1942

MORGAN MARTIN, M.D.
Norwich, Conn.

Mental Retardation: An Atlas of Diseases with Associated Physical Abnormalities, *by Lewis B. Holmes, M.D., Hugo W. Moser, M.D., Saevar Halldórsson, M.D., Cornelia Mack, M.S., Shyam S. Pant, M.D., and Benjamin Matzilevich, M.D. New York, Macmillan Co., 1972, 383 pp., $28.*

This is the most recent of the many books published over the past decade which have attempted to compile, for the benefit of the clinician, the many syndromes that involve chromosomal disorders, inborn errors of metabolism, neurologic disorders, and congenital malformations. As far as the field of mental retardation is concerned, this atlas is probably the most detailed and sophisticated that has yet appeared.

The authors begin appropriately with a discussion of mental retardation. However, at this point they should have inserted a bibliography of the basic texts and atlases that survey in great detail many of the disorders discussed in this work. The book itself is divided into seven chapters: "Metabolic and Endocrine Diseases," "Progressive Diseases of Unknown Cause," "Acquired Conditions Associated with Mental Retardation," "Chromosomal Abnormalities," "Central Nervous System Malformations," "Syndromes of Multiple Deformities," and "Neurocutaneous Syndromes with Mental Retardation." Each entity within these categories is fully discussed and accompanied by an excellent, up-to-date bibliography and at least six excellent photographs. The book is well indexed.

Although the classification system adopted by the authors is a good one, there should have been a much clearer organization within these categories. For instance, under the metabolic disorders, the various GM gangliosidoses could have all been assembled together, listing first GM 1 gangliosidosis and then the three variants of GM 2 gangliosidosis. Also, the discussion of the metabolic and endocrine disorders would have been facilitated by the use of chemical formulas demonstrating the metabolic pathways and the enzymatic defects.

The author's categorization of some entities is questionable. If the Prader-Willy syndrome is listed under endocrine disorders, why are the Riley-Day, Lowes, and Laurence-Moon-Biedl syndromes placed under syndromes of multiple deformities? Cretinism is appropriately placed under the metabolic and endocrine disorders, yet despite the authors' statement, most cases are athyrotic, thus representing a congenital maldevelopment. Some entities are included that are generally not associated with mental retardation, such as Riley-Day syndrome, ataxia telangiectasia, and thalidomide teratogenesis.

The so-called kinky hair syndrome, first described by Menkes in 1962, has now been found by Danks and associates (1) to be an inherited defect in copper absorption. Discussion of this syndrome should have been included in chapter 1, not in chapter 2. As the authors predict, there will be many more such changes in the future.

The poorest section is chapter 3, which deals with acquired conditions. Here prematurity and anoxia are omitted, yet erythroblastosis is included. Most irrelevant is a discussion of warfarin, where only two cases are known, and thalidomide, which is no longer available and did not cause mental retardation. Yet lead poisoning, mentioned in the introduction, is not separately discussed. This is a major omission. This whole chapter needs a careful revision.

In conclusion, one can say that this book is a valuable addition to the working library of anyone in the fields of mental retardation, genetics, neurology, and pediatrics. However, I feel that I should in all candor state that the publisher and authors alike should think twice before embarking on another such project. As the number of such books increases, the overlapping increases. It means one more book to buy and one more book to look up. It would be more profitable to revise those already available. I hope that the authors will be able to revise this book many times in the future.

REFERENCE

1. Danks DM, Campbell PE, Stevens BJ, et al: Menkes's kinky hair syndrome. An inherited defect in copper absorption with widespread effects. Pediatrics 50:188–201, 1972

MARIO VALENTE, M.D.
Los Angeles, Calif.

Semantics: An Interdisciplinary Reader in Philosophy, Linguistics and Psychology, *edited by Danny D. Steinberg and Leon A. Jakobovits. Cambridge, Mass., Cambridge University Press, 1971, 599 pp., $16.50.*

This book is a splendid invention to meet the needs of the in-

quiring student in a wide-ranging area. It is what it purports to be, namely, an interdisciplinary reader or anthology of earlier outstanding articles by leading authors in three fields with major concern in semantics. It brings together 33 essays, most of which have been previously published elsewhere, by 34 authors, some of whom are well known not only in their own fields but also in the field of psychiatry.

Each of the three sections has a well-written overview. The overview for philosophy (pp. 3–13), by Charles E. Caton, gives us a good platform from which to plunge into difficult problems. Howard Maclay's overview for linguistics (pp. 157–184) is an excellent introduction to the complex tasks of defining the boundaries of an overexpanded linguistics and the future relations to psycholinguistics and human communications. The overview for psychology, by Danny Steinberg (pp. 485–495), gives us a quick view of the growth of behavior theory from the days when psychology had little to offer about an understanding of semantic problems to present-day efforts. This chapter alone will be helpful to those teachers who wish to discuss various facets of the problem of meaning with their classes.

The book is dedicated to Charles E. Osgood, a psychologist-psycholinguist at the University of Illinois who has worked on problems of aphasia and is a national leader in the area of psycholinguistics. Osgood has a chapter (pp. 497–528) on "Where Do Sentences Come From?" that will be of considerable interest to all clinicians and scientists interested in human behavior on several fronts. His searching inquiry into the roots of the presuppositions that lie behind the production of sentences leads him to survey wide horizons in linguistics, behavioristic psychology, and generative linguistics, with excellent critiques of their respective deficiencies to provide tenable models for "the speaker."

Osgood's presentation of a two-stage learning theory called "representational mediation theory," based upon his own contributions and the work of C.L. Hull (in the early 1930s and 1940s), Miller and Dollard (in the early 1940s), Mowrer, Goss, and the Kendlars (in the early 1960s), will revive many memories and hopes in readers who want a stronger and more stimulating learning theory on which to build experiments. Osgood closes with a few choice paragraphs on the problems of "language universals," with recommendations for further studies. This essay illustrates well the impossibility of doing justice to this book, because a genuine discussion of the articles would in most cases require space equal to the original.

I will try to mention most of the contributors by name in order to give the reader an introduction to them.

David McNeill, a linguist from the University of Chicago, has some sharp remarks (pp. 530–535) on "Are There Specifically Linguistic Universals?" Eric H. Lenneberg is represented by a chapter on "Language and Cognition" from his book *Biological Foundations of Language* (1). As might be expected, articles by Noam Chomsky, Jerry A. Fodor, George A. Miller, J.J. Katz, James D. McCawley, George Lakoff, Uriel Weinreich, D.T. Langendoen, and Paul and Carol Liparsky are reprinted. They cover their respective fields of competence such as the role of semantics in a grammar and the area of meaning, presupposition, and reference. The field of "the lexicon" is covered by articles by Charles J. Fillmore, Edward H. Bendix, Manfred Bierwisch, R.M.W. Dixon, and Kenneth Hale.

There are 12 essays representing "analytic philosophy," but I will not describe them or their authors because of space requirements and because they may be of less interest to clinicians than the articles previously mentioned. However, these 12 essays are well worth the hard work necessary to read them.

This book can be recommended with enthusiasm to all students of human behavior who want a genuine overview of the varied problems in semantics and language. It is a strong insurance against narrow provincialism. It will disappoint those who want easy answers to hard questions or cookbook formulas to approach the study of those subtle media by means of which we live together. We are just beginning to learn to define a very few primitive methods by which we can study human communication systems. We can hope for better insights into disordered behavior if we have better mastery of the communication process between living people.

REFERENCE

1. Lenneberg EH: Biological Foundations of Language. New York, John Wiley & Sons, 1967

HENRY W. BROSIN, M.D.
Tucson, Ariz.

Dementia Praecox and Paraphrenia *(facsimile edition), by Emil Kraepelin, translated by R. Mary Barclay. Huntington, N.Y., Robert E. Krieger Publishing Co., 1971, 328 pp., no price listed.*

This book is a translation of volume 3 of Kraepelin's eighth edition of his textbook of psychiatry (1). When it was published in 1919 it filled a need because English psychiatrists, not familiar with the German text, were not inclined toward Kraepelin's teaching. Now the book is valuable as a historical document, especially since numerous references offer an opportunity to become acquainted with the contributions of many little-remembered authors.

This book should be evaluated in the setting of Kraepelin's psychiatric development. In the fourth edition (1893), in which he formulated disease entities based on etiology and the course of the illness, he singled out manic-depressive insanity. In the fifth edition (1896) he presented his concept of dementia praecox, which included the largest group of patients in psychiatric hospitals. His publication offers a careful description of the manifold symptoms that he and others had observed. The illness was characterized by onset in adolescence and progress into a dementia of varying degrees. In the sixth edition (1899) he elaborated his unifying concepts, and he further did so in 1903. Although publications dealing with the onset of the illness in later life had appeared and were also confirmed by Kraepelin, he preferred to keep using the term dementia praecox.

In the period leading to the eighth edition (1913) the dynamic concept of psychopathology was stressed by the psychiatric group of Burghölzli (E. Bleuler, Jung), culminating in Bleuler's *Die Gruppe der Schizophrenien* (2). Kraepelin accepted Bleuler's separation of fundamental and accessory symptoms. He appreciated Bleuler's application of psychoanalytic interpretations but rejected Freud's theories. In the incomplete ninth edition (published posthumously by J. Lange in 1927) a more positive evaluation of Freud's work was offered. This edition did not include some clinical chapters (e.g., dementia praecox and manic-depressive disease). A publication by Kraepelin in 1920 (3) demonstrated his changing understanding of psychiatric classification. He stated that schizophrenic symptoms may occur in manic and depressive illnesses and manic and depressive episodes in a schizophrenic illness. Dementia praecox is considered a special entity in the group of schizophrenic illnesses.

It is of interest to note that Kraepelin doubted the importance of autism (introduced by Bleuler in 1911). In the period after Kraepelin and Bleuler, this feature became a central point

in treatment, especially through the influence of phenomenological psychopathology (L. Binswanger) and the clinical teaching of Manfred Bleuler. (His father had recognized the therapeutic importance of the correction of autistic withdrawal by early discharge from the hospital, and he later supported "prolonged sleep treatment" to permit a therapeutic contact.) Kraepelin's understanding of schizophrenic patients is illustrated by his inclusion of a patient's description of the early development of her acute schizophrenic illness. He also referred to Schreber's book (4), published in 1903 and analyzed by Freud in 1911.

The last part of the book includes Kraepelin's presentation of paraphrenia, a paranoid reaction that he separated from dementia praecox and related to Magnan's *délire chronique.*

The introduction to this facsimile edition, written by Ernst Harms, is an interesting discussion of the historical setting of 1913.

REFERENCES

1. Kraepelin E: Psychiatrie: ein Lehrbuch für Studierende und Arzte. Leipzig, Germany, JA Barth, 1913
2. Bleuler E: Dementia praecox, oder Gruppe der Schizophrenien. Leipzig, Germany, F Deuticke, 1911
3. Kraepelin E: Die Erscheinungsformen des Irreseins. Z Neurol Psychiatrie 62:1–29, 1920
4. Schreber DP: Denkwurdigkeiten eines Nervenkranken nebst Nachtragen und einem Anhang uber die Frage. Leipzig, Germany, Oswald Mutze, 1903

OSKAR DIETHELM, M.D.
New York, N.Y.

Organizational Diagnosis, *by Harry Levinson. Cambridge, Mass., Harvard University Press, 1972, 557 pp., $20.*

Sigmund Freud suggested two essential characteristics necessary for a reasonably successful life: "to love and to work." Psychiatrists have spent a great deal of time and energy discussing and writing about love. For reasons that are not totally clear, the psychiatric literature has paid little attention to the study of work.

Professor Harry Levinson has spent most of his professional life investigating and analyzing individuals in the world of work. His earlier books reflect his concerns regarding specific symptoms of individuals within corporations (accidents, absenteeism, and alcoholism). He stressed the point that the way in which organizations were managed had considerable impact upon the mental health of the people who worked in them. To understand emotional distress in industry, one therefore had to understand the organizational milieu as well as the individual at work.

His latest book, *Organizational Diagnosis*, is a "gathering guide"—a tool to be used by consultants as they attempt to analyze, synthesize, and establish dynamic formulations so that they may offer sophisticated recommendations to management.

Dr. Levinson uses psychoanalytic and systems theory to formulate his diagnostic model. He states:

> An organization is a living system. It has components, which taken together comprise its whole. These components interact with each other and comprise the whole with other wholes, and its own environment. It grows and develops, has a history, experiences crises, and adapts. An organization, then, is like any other living system. Therefore modes of systematically studying and evaluating other systems might be extrapolated to the study of organizations.

A significant part of the book is in outline form and addresses itself to three central questions: What data do you gather? How do you order it? What do you do with it?

Part 1 serves as a guide for using the outline and offers practical suggestions regarding entry into an organization. It also includes the various techniques involved in the study procedure, with specific emphasis on organizational structure, methods of sampling interviewees, and the observations of people at work.

The psychiatrist will feel very much at home with Part 2, for it parallels, to a certain degree, the classical psychiatric history. Levinson states, "The most highly systematized examinational procedure for a living system is that used for the physical and psychiatric examination of the individual person." This section contains the case study outline, which includes the genetic and historical data of a company, a descriptive analysis of the organization as a whole, interpretive data, dynamic formulations and conclusions regarding the company, and specific prognoses and treatment recommendations.

In Part 3 the principles of the organizational diagnostic process are used to analyze the Claypool Furniture Company.

Part 4 outlines the closure process, which includes preparing and presenting the report and anticipating the manager's reaction to it.

The psychiatrist should find Parts 1 and 4 to be the most interesting, primarily because they focus on the interpersonal dynamics between the consultant and the manager. These sections analyze some of the anxieties of both parties involved and the reactions (not always positive) to the recommendations of the consultant. Of particular interest is the predictable course that follows the reading of the report: the defensive hostile phase, followed by a discussion of feelings and issues, and subsequently leading to a stage of consolidation.

During the past 60 years an enormous amount of literature has been devoted to the field of organizational behavior. In the early 20th century Taylor and Gilbreth best exemplified the mechanistic, scientific approach regarding time and motion study in analyzing men at work. Then, in the late 1920s, 1930s, 1940s, and early 1950s, Mayo and Roethlisberger, of the Harvard Business School, pioneered the studies of human relations in organizational life. William White and Elliot Chapple, utilizing the principles of applied anthropology, and Kurt Lewin, utilizing the techniques of group dynamics, made further inroads in this area. Much of the literature of the 1950s, 1960s, and early 1970s owes its formulation to the works of Freud, Maslow, Rogers, and Merton, to name but a few.

This short history should give some indication of the overlapping of an incredible number of disciplines in the field of organizational behavior; hence the difficulty in trying to develop a diagnostic study outline.

This significant book could only have been written by a superbly trained "clinical academician," one who has organically enmeshed himself into organizational life and who has gathered together his unique experiences. It is clearly written and manifests great sensitivity to the client's feelings. As Professor Levinson states, "The consultant should be careful not to overwhelm the client with negative feelings, that leave him with disproportionate feelings of helplessness, therefore unable to act. He should make it clear that he is not there to tell them how to run their organization. His job is to gather organizational information."

This is not a cookbook; it is a guide, a tool to be used by individuals engaged in organizational consultation. No psychiatrist

can memorize this book and become an organizational diagnostic expert. It stresses the need for the consultant to be involved in the organization, and it further reinforces the need for a detailed history, perceptive clinical examination, and a sophisticated dynamic formulation before treatment and recommendations can be made. It follows the best tradition of medical practice. It is a most valuable book and, one may hope, will stimulate more psychiatrists to investigate individuals in the world of work.

BARRIE S. GREIFF, M.D.
Boston, Mass.

Symbol, Dream, and Psychosis, *by Robert Fliess, M.D. New York, International Universities Press, 1973, 425 pp., $13.50.*

This book represents the third and final volume of the author, a psychoanalyst who died in 1970. It begins with a chapter devoted to the symbol, then one that deals with various aspects of dreams, followed by one on ambulatory psychotic patients and one on what the author refers to as "exceptional states," primarily hypnotic in nature. There follows a section on technique, with a chapter on the analytic relationship, particularly as it relates to transference and countertransference. Then there is a chapter in which the author describes the technique of amnesia removal and finally one on the diagnosis and treatment of the ambulatory psychotic.

The author, the son of an internationally famous psychoanalyst, was obviously well acquainted with Freud's writings as well as with those of other prominent analysts. In most respects he agrees with Freud's basic proposals but in certain areas either expands or modifies them. For example, symbolism is a topic that does not lend itself to preciseness. To some patients certain symbols represent what we have come to consider traditional things, but in other patients such symbolism will vary because of their own backgrounds and even because of recent experiences. There are some patients who use dreams constructively, while others remain amnesic for their dreams and still others overwhelm the analyst with a plethora of dreams, to the point where it becomes impossible to deal with them all.

The author deals extensively with the problem of the sexually abused child. It is his contention that the majority of adult neurotics have been abused as children and that in most instances the adult abuser, usually a parent, was psychotic. Unfortunately, he does not make clear his differentiation between neurotic and psychotic but seems rather to assume that the reader will agree with this differentiation.

The book has many short case vignettes, but these are often so brief that they leave the reader wondering whether Dr. Fliess has drawn the correct conclusion.

Freud felt that many patients related childhood traumata that were in fact fantasy. The author feels that most of these are covered by amnesia of the true event and that, in fact, it or something akin to it did happen. He feels that such amnesia can be uncovered if properly handled.

In general, this could be described as a wordy book that often uses too many words to explain a concept and then does so in an unclear fashion. One could also take issue with the author's relatively casual use of the word "psychotic" as well as his frequent references to such parents as "beastial." Certainly one can agree that the use of symbolism, dreams, and the presence of psychosis may well be related in many patients. Unfortunately, in reading the book one gets the impression that the abused child almost invariably has a psychotic parent. More recent work on the physiology of sleep and the battered child is not included primarily because of the time at which the book was written.

This book might be somewhat helpful to the practicing analyst but will probably not find a wide market among general psychiatrists or the rest of the mental health professionals.

STUART M. FINCH, M.D.
Ann Arbor, Mich.

Genetic Diversity and Human Equality, *by Theodosius Dobzhansky. New York, Basic Books, 1973, 123 pp., $5.95.*

From time to time there appears a small book, deceptively easy to read, written usually by a distinguished thinker who has had a long and productive career, that illuminates an important area of human involvement and scientific thought. I have a special shelf for such books, and this one belongs on it. According to the dust jacket and the foreword, it purportedly deals with "the facts and fallacies in the explosive genetics and education controversy." Actually, this book by Dr. Dobzhansky, one of the world's foremost geneticists and an expert on evolutionary theory, contains three rich essays and is much more extensive in scope.

In the course of his discussion on genes and environments, the author indeed points out the importance of his concept of "reaction range"—"Similar genes may have different effects in dissimilar environments." In this context, while accepting the inference from family and twin studies that individual IQ differences have large genetic components, Dobzhansky remains unconvinced, on the basis of present evidence, that class and racial differences in IQ averages cannot be attributed to environmental factors.

Turning to broader issues, Dobzhansky roams over the topic suggested by the title of the book and in a fascinating manner develops the paradoxes posed by human genetic diversity. For example, if social and economic inequality is fixed by caste, class, or racial boundaries, the genetic potential of an individual has no chance to find its proper niche and reward. On the contrary, with freedom of opportunity to choose one's goals and be educated therefor, socioeconomic classes can give way to "aptitude aggregations," fluid from generation to generation, with genetics playing a larger, rather than a smaller, role in determining fitness and choice.

In an essay on the evolutionary genetics of race, the author forestalls any pejorative connotation by defining races as "subordinate Mendelian populations ... which differ in the incidence of some genes in their gene pools," with the classification of races a pragmatic affair rather then one based on eternal and mutually exclusive types. He discusses the roles of natural selection, random genetic drift, and gene exchange in the shifting evolution of racial groups, and he emphasizes the uniqueness of man, whose language and educability make possible cultural change as well.

It has sometimes been judged that the only ethics compatible with the concept of evolution is that of tooth and claw, of inequality and fierce competition. Dobzhansky does much in this book to point out that this may not be true, that man at least, cognizant of evolution, may work creatively with his fellows to obtain the maximum benefit for all and may discover value and perhaps even meaning in the process.

Psychiatrists as scientists, as humanists, and as citizens will

do well to put aside their more professional literature for an evening and read these essays.

JOHN D. RAINER, M.D.
New York, N.Y.

The Art of Dying, *by Robert E. Neale. New York, Harper & Row, 1973, 158 pp., $5.95.*

At first glance this book seems to be a manual for dying, a sort of do-it-yourself series of expositions or essays on death and dying, followed by questionnaires. The author refers to the latter as "exercises" for the reader to explore to discover his own feelings about the subject. But all this is deceptively simple; the book is actually a very profound one. It is "a descent . . . into the chaotic hell of our denial of death, fear of life and suicidal living."

Robert Neale writes in the existentialist tradition of Heidegger and Camus. His basic premise is that death is a highly personal experience, perhaps *the* most personal one, and in the flight from death one flees the self as well: "Our fear of death is our fear of life . . . a screen on which to project all our concerns about life." This connection between life and death is emphasized as the author draws from all aspects of life and literature to learn about death; then with grief as a hub he reverses to show that to deal with one's feelings about death is to confront one's existence, one's life.

The author is a parish minister, a chaplain, and currently Professor of Psychiatry and Religion at the Union Theological Seminary in New York. This experience, his philosophical bent, and the death of a brother have motivated him to search himself for his deepest feelings toward his own death and dying. This he shares with the reader, urging him to do the same without judgment as to what might be the right or wrong way to feel. This is so despite suggested answers to exercise questions that seem at times weighted in favor of a positive outlook, as if to lead the reader to awareness of a new point of view.

The author's style is easy and conversational, although at times somewhat sermonic. (Perhaps, because he is a clergyman, this is his idiom, and thus he is entitled to use it.) Since he draws on a wide variety of sources, the book is not a rigorously argued academic treatise, but rather an intensely personal essay offering one perspective on how to approach death. Because anxiety about death and separation, even in others, is a manifestation of our own introjected fears of oblivion, the death approached must be one's own. Oblivion may be not only a somatic death, but an existential death or flight from self as well. Thus approaching death (and therefore oneself) may enrich the quality of life; the art of dying is the art of living.

Neale feels that he is "trying to deny death in writing these exercises." We agree, but there is more. He is also trying to remove the mystery in and around his own death, thereby in a sense defeating, or at least mastering, death. Such an effort may be defensive, but it encourages utilizing defenses in coping with the inevitable rather than in a futile attempt at flight.

Yet the flight is not only the patient's. The goal of medicine is the promotion of life, not its prolongation; yet the physician often sees death (his own and others') as an enemy always to be resisted. In order to be truly helpful, the doctor must accept the ineluctable nature of death as a life event:

> We should not try to give the ego support by building up its hopes, prescribing medical remedies, or dispensing superficial consolations. We are to stop treating the individual as a patient who can be cured. We give up our own hope for the individual. By so doing, we become able to accept the individual's own experience. Then, in the keeping of a kind of death vigil together, the panic reaction diminishes, and with it the hasty assault on death (pp. 68–69).

Thus the efficacy of *The Art of Dying* is twofold: in its perspective on the helper-patient relationship and in the self-insight of the reader-therapist. (Incidentally, this quotation could well serve as a paradigm for insight therapy.)

The chapters are concerned with the degrees of awareness of death, the fears involved, suicide and all of its ramifications, grief and its tasks, "life in death" (concepts). These topics are subsumed under three sections: Death, Gestation, and Rebirth. While this book seems to be directed toward the clergyman, we feel that it makes a significant contribution to the problem of death and dying. It is appropriate for everyman. This includes the psychiatrist as well as those helping professionals more intimately involved with the dying. Robert Neale's book is a most welcome addition to the growing literature.

NATHAN SCHNAPER, M.D.
H. WILLIAM SCHNAPER
Baltimore, Md.

Group Therapy: 1973—An Overview, *edited by Lewis R. Wolberg and Emanuel K. Schwartz. New York, Intercontinental Medical Book Corp., 1973, 228 pp., $12.50.*

This is the first volume in an annual series that proposes to summarize the present status of group psychotherapy. "The emphasis is on the practical personal experience of recognized workers, and they explicate both traditional and advanced ideas," according to the publisher's flyer. There are 18 papers in this volume, authored by Alexander Wolf, Bernardo Neto, Hyman Spotnitz, Martin Grotjahn, Raymond Corsini, Irvin Kraft and Jody Vick, Bernard Riess, David Mendel, Asya Kadis and Max Markowitz, Harold Leopold, Helen Durkin and Henriette Glatzer, Leon Grinberg, Walter Schindler, Edrita Fried, Jay Fidler, Henry Ezriel, S. H. Foulkes, and E. James Anthony—certainly an impressive list of recognized workers.

I approach such annual volumes with an affective response similar to that aroused by a smorgasbord. I anticipate finding a few rare and delectable tidbits, disliking some rather intensely, and being indifferent toward the majority. Edited volumes are frequently uneven in the quality of their style and content. This small volume proved to be an exception. All the papers are well written, the introductory summaries are excellent abstracts, there is a wide sampling of issues, and the content is significant.

The subject matter ranges over acting out, treatment problems with adolescents, family therapy, transference-countertransference problems, training in group psychotherapy, variants of group techniques, group bonds, communication networks, and the dynamics of therapeutic effect. Two papers deserve special attention.

In "Psychotherapy of a Group of Deaf Mutes," Bernardo Neto describes his experience with five deaf mutes (three men and two women). "Fingers take the place of the mouth. Hearing is transferred to the eyes. . . ." Dr. Neto acquired the ability to use the deaf mute alphabet; he also demonstrates his ability to use the written word. He introduces the reader to the patients, then proceeds through the initial phases of this unusual group to the crisis that developed after six months of treatment, when he became more sure of himself. With candor, Dr.

Neto describes the countertransference issues that arose and his attempts to understand the growing chaos that developed around him and within him. That he was able to do so, and to let his patients know it, proved to be of immense help. I found this paper to be a sensitive narrative of a therapist's real struggle to help a group of uniquely disadvantaged people as well as an allegory of "every therapist's" struggle with the therapeutic situation, his patients, and himself.

Many attempts have been made to discuss transference, transference neurosis, the technique of transference interpretation, and transference in groups. In "Psychoanalytic Group Therapy" Henry Ezriel offers one of the most succinct discussions of these issues that I have encountered. I recommend this paper to all students of psychotherapy and psychoanalysis as well as to those specifically interested in group psychotherapy.

This first volume is presented by the editors as a memorial to Asya Kadis, the former director of group therapy at the Postgraduate Center for Mental Health. It is a fitting tribute to her. Subsequent to the publication of this volume Emanuel K. Schwartz, one of the editors, suddenly and tragically died. This volume thus becomes a memorial to him as well. It is hoped that future editors will maintain the high standards that Drs. Wolberg and Schwartz established in this first volume.

STANLEY L. BLOCK. M.D.
Cincinnati, Ohio

Human Sexuality and the Mentally Retarded, *edited by Felix F. de la Cruz and Gerald D. LaVeck. New York, Brunner/Mazel, 1973, 340 pp., $8.95.*

There are precious few issues in the care and management of the mentally retarded which precipitate the amount of direct verbalizations and feelings that the topic of their sexual adjustment does. Unfortunately, these frequent and swirling discussions often generate more heat than light on the crucial issues involved in this area of human adjustment.

Although the sexual dimension of the symptom of mental retardation has been a traditional focus of study for psychiatrists involved in this area of clinical endeavor, there have been many recent events that have drastically altered the "traditional" issues involved. For example, the recently published longitudinal studies of the sexual adjustment of large groups of young retarded citizens, the Pill, the rapid move toward community-based programs for the retarded (coupled with citizen advocacy programs)—as well as other recent trends—strongly suggest the need for a current review of this area.

The editors of this book set out to capture the current professional ferment in this area by initially having an international conference (in late 1971), then editing the conference proceedings and publishing them in this book. In the preface they state that they wanted to review what is known and what remains to be studied about the role of sexuality in the development and behavior of the mentally retarded. They sought a balance between the biological-developmental approaches to this particular facet of the symptom of mental retardation and the subjective-personal needs and societal expectations of retarded citizens within the mainstreams of our society.

The book includes 22 contributions, which are arranged into four sections: psychosocial development and sex education, physical and biological aspects, institutional and community attitudes and practices, and new clinical directions for research and experimental programs. The first section contains four excellent presentations on the developmental aspects of sexuality in the retarded, including the issues involved in providing sex education within the learning environments of retarded citizens.

The second section focuses on family planning programs, methods of contraception, and the possible epidemiological impacts on the gene pool of the currently changing pattern(s) of sexual expression among the retarded. Each of the four contributions in this section presents a fine balance between succinct theoretical foundations and pragmatic guidelines.

The third section of this book, titled "Institutional and Community Attitudes, Practices, and Policies," is a remarkable collage of national-international studies on the patterns of sexual expression of the retarded in a variety of residential settings, the impact of community attitudes on expectations, and moral-ethical-legal dimensions of sexual relationships among the retarded. These presentations reflect the actual experiences of clinicians in a variety of settings, and the theoretical aspects are interpreted within their respective frameworks of service and experiences. Each of the seven contributions to this section is a gem.

The next section deals with research and includes an endocrinological focus on the development of systems and mechanisms for expressing sexuality in adults, as well as social-cultural research considerations. Included is a very lucid review of possible future research studies that would integrate cultural and biological factors into specific research strategies for directly altering the expression of sexuality in the adult retardate. The concluding section of this book, "Background Papers," provides an international perspective on sex education replete with analyses of recent survey data on the rapidly changing trends and attitudes toward premarital and postmarital sexual behavior.

Each of the five sections of this book includes a synopsis of the question-and-answer exchanges that followed the initial presentation of these papers. These discussions are a distinct highlight of the book, since the discussants are nationally known individuals in the field of mental retardation and they focus directly on both current issues and those challenges which are on the professional horizon at this time.

The editors have accomplished a prodigious effort in presenting a publication that is of uniformly high quality as to the contributions included, well-balanced as to national-international trends, and in an interesting, readable format. The contributors to this book, by their in-depth approach to the special issues inherent in their topics, have provided an interesting and most timely assessment of the general and specific dimensions of the expression of sexuality by "deviant" (or "normal"!) citizens in our society.

FRANK J. MENOLASCINO, M.D.
Omaha, Neb.

The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders *(Monograph Series of The Psychoanalytic Study of the Child, no. 4), by Heinz Kohut, M.D. New York, International Universities Press, 1971, 343 pp., $12.50.*

This book is a finely done intaglio. The central focus is on those unfortunates who never successfully master the critical step from childhood narcissism to the broader world of reasonable balance between narcissism and object relations. Kohut manages in just over 300 pages to sketch and then to etch in the reader's memory this imbalance, which he calls narcissistic per-

sonality disorder. The text shifts from clinical to theoretical with great effectiveness. The intaglio effect is achieved by reading the entire manuscript in which all these things are shown in precise relationship to the narcissistic imbalance: genetic development in the psychoanalytic sense, the relationship of narcissistic disorders to other clinical entities, the treatment problems that are unique for this formerly untouchable area of human psychopathology, the special problems of countertransference that such patients arouse in most persons who meet them as well as in those who treat them, and some special gains by squarely and fairly meeting the varieties of transference demands made upon the analyst—for example, greater creativity, empathy, and, at times, humor.

The information given in this book was hard won and represents years of both clinical and theoretical experience. For the therapist to make use of this information will require more than hard work. In the first place, it will interest only those therapists who are willing to expose themselves for long periods of time to the vicissitudes of the human psyche. Those looking for short cuts or answers will not like Kohut's manner or message. In the second place, since this monograph represents what may well be the signal work in a new area of psychoanalysis, it can be read profitably only by those who have some familiarity with psychoanalytic literature. Certainly the reader need not be a fully trained psychoanalyst, but he should not have to struggle with the fundamental assumptions of analysis, at least in their evolving theoretical aspects. In the third place, the reader should identify his own capacity for two things before attempting this book: his ability to retain ideas over long Germanic sentences and over the entire scope of the book and his own exposure to clinical material from his own experience to enliven the text and make its reading a true learning experience.

If these several conditions can be met, the book will more than repay reading and rereading. It should prove especially helpful to the thoughtful practitioner who has to depend upon his own reading and his own practice to grow in therapeutic skill. Psychoanalysts will find some points to argue with, but will also find the book on the must reading list for some time to come.

RAYMOND HEADLEE, M.D.
Elm Grove, Wis.

Fact and Fantasy in Freudian Theory, *by Paul Kline. New York, Barnes & Noble (U.S. distributor), 1972, 394 pp., $16.*

In this book Dr. Kline reviews a large number of studies that have subjected various parts of psychoanalytic theory to empirical tests. He has undertaken this task because he believes that while the validity of all of psychoanalytic theory has not been established, there is no theory that better explains the many observations on which it is based and there is no evidence that refutes the entire complex.

His aim is to establish which parts of Freudian theory have been or could be confirmed by objective scientific research. His criteria for objective research are that the sample and controls be adequate, that the tests used to establish validity be valid themselves, that the results be capable of statistical analysis, and that the conclusions of the study be relevant to psychoanalysis. He acknowledges that he cannot review all of the hypotheses contained in Freud's writing, but has chosen those which he considers to be most significant. Dr. Kline reports the experiments in reasonable detail. He critically reviews the validity and reliability of the conclusions and discriminates between those studies which he believes validate analytic theory, those which refute it, and those from which no conclusions can be drawn.

Dr. Kline's book presents two major problems. One is the issue of validation of theory in disciplines such as psychoanalysis where the data do not easily lend themselves to mensuration. Only in the physical sciences can the variables be adequately isolated and held sufficiently constant to easily demonstrate cause and effect. In the biological and social sciences such an approach is often extremely difficult because the phenomena studied are in a state of flux and because they are multidetermined. Variables cannot be easily isolated or manipulated. Knowledge in these areas is acquired largely through a historical approach, i.e., observation over a period of time. The genetic approach is basic to psychoanalysis, and any consideration of its validity has to take this into account.

The studies reported by Dr. Kline deal, for the most part, with contemporary attitudes. Even when they include historical data, these are arrived at by the recall of material readily available to consciousness. This disregards the possible importance of factors of which the subject may not be aware and of which he can become aware only over a period of time. The problem of measurement is further complicated by the validity of the measuring tools. In the studies reported the tools used, such as questionnaires, rating scales, and inventories, are not of the same order of precision as the tools used in the physical sciences, and therefore the results are less definitive and are difficult to evaluate.

The second problem encountered in this book is that of definition and interpretation of psychoanalytic concepts. That Dr. Kline is aware of the complexity of the subject is indicated, for example, by his discussions of both the changing concept of defense and the difference between imitation and identification. However, he sometimes tends to accept simplistic, outmoded, or even inaccurate concepts. This is illustrated in parts of his discussion of dreams, homosexuality, and the structural theory.

Attempts to correlate the knowledge gained from statistical analyses and direct observations of behavior with the insights gained from psychoanalysis are particularly pertinent at this time when learning theorists, behavior therapists, and psychoanalysts sometimes fail to recognize the areas in which their interests overlap and present their ideas as if they were mutually exclusive. While pointing out some of the difficulties encountered in attempting to demonstrate these correlations, Dr. Kline also indicates some areas in which they occur. While there is reason to question some of Dr. Kline's assumptions and judgments, his book presents an extensive and well-organized review of the subject and could be helpful to those working in this field.

REBECCA Z. SOLOMON, M.D.
Hartford, Conn.

Homosexuals and the Military, *by Colin J. Williams and Martin S. Weinberg. New York, Harper & Row, 1971, 214 pp., $8.95.*

This sociological research study involved an experimental design in which a comparison was made between a group of men who received honorable discharges from the armed services and a comparable group who received less than honorable discharges, all having been identified as homosexual.

Background statistics indicate that at least 90 percent of service personnel leave with honorable discharges, five to six percent with general or undesirable discharges, and one percent or

less with bad conduct or dishonorable discharges. Educated guesses suggest that perhaps 2,000 separations per year were for homosexual reasons during the late 1940s to mid 1950s. Available statistics do not provide accurate information as to the type of discharge given.

The research sample was selected from completed questionnaires sent to homosexuals in New York City and San Francisco. Of 872 questionnaires sent to members of the Mattachine Society of New York, there were 51 returns by individuals who gave permission for an interview and who had had military experience. Of 500 questionnaires sent to members of the Society for Individual Rights in San Francisco, there were 85 "useful" returns. In all, there were 32 individuals who had received less than honorable discharge due to homosexuality. A similar, matched control group was randomly chosen from the remainder, i.e., those who had received honorable discharges and whose homosexuality had not been discovered. Two central questions guided the research: How does a person become officially labeled as homosexual, and what are the consequences of leaving the military with less than an honorable discharge?

In answer to the first question, there seemed to be three main patterns: those who were caught through their own indiscretion, those who voluntarily admitted homosexuality in order to leave the military service, and those who were discovered through another person. The third pattern was the most common, although the authors give no figures. There were no "bum raps" reported. In answer to the second question, the authors conclude that while the less than honorable discharge may initially be very traumatic, most persons do not suffer any long-term negative effects.

The authors found no significant differences in the effects of an honorable versus less than honorable discharge on the subsequent lives of homosexuals. Nonetheless, in an epilogue they give their personal opinion that military policy concerning homosexuals is unwise, unjust, unenforceable, and immoral. While the authors may be right, their opinions are not supported by their research.

JOHN M. CALDWELL, M.D.
Miami, Fla.

Development of an Urban Mental Health Center, *edited by H.G. Whittington, M.D. Springfield, Ill., Charles C Thomas, 1971, 199 pp., $9.50.*

Dr. Whittington and eight co-workers recount here their experience since 1965 in establishing a comprehensive mental health program to serve over half a million people in the city and county of Denver, Colo. Most of the book deals with the specific programs established for 200,000 people in northwest Denver, a large number of whom are Spanish-American and black and a major proportion poor.

The first several chapters, written by Dr. Whittington, succinctly state the philosophy, basic principles, and administrative procedures upon which program planning is based. Phrases such as "clinical problem solving" and "pragmatic utopianism" are translated into action programs. The involvement of community institutions and agencies and the focus on a family approach to individual problems are constant themes interwoven in all discussions of programs. Dr. Whittington also states his functional criteria for defining a comprehensive community mental health center—"a new 'service delivery system' designed to correct deficiencies in the multiple systems which preceded it" (p. 26). The criteria begin with the question "Does the agency reflect in its beliefs and programs, the conviction that human behavior and misbehavior are in part socially rooted?" It also includes an emphasis on preventive aspects of psychiatric practice, flexible use of therapeutic and preventive modalities, and redeployment of professional resources. It ends with the question "Do citizens participate in policy setting?" (p. 28).

The Denver program is subdivided into geographic catchment areas with a multidisciplinary team assigned to each subarea. Two teams are stationed in neighborhood health centers. Each team is responsible for all adult and child outpatient, consultation, and follow-up services. Inpatient and day-care services are centralized in the Denver General Hospital, with each team assuming regular care and contact with patients from its designated catchment area. This method of functioning appears practical and economical. For instance, each generic team spends about 50 percent of its time in direct clinical services (15 percent in evaluation, 15 percent in individual treatment, and 20 percent in group therapy), 15 percent in treatment and preventive activities for alcoholics, ten to 25 percent in consultation, and 15 percent in record keeping, team communication, and administration.

The contributors describe their individual experiences: the nurse in the emergency room, the rehabilitation counselor assigned to a team, the development of a generic team stationed in a neighborhood health center, and the planning of a comprehensive and accessible program in another neighborhood health center. They also describe how the hospital program meshes with the generic teams and the development of a program for long-term institutionalized state hospital residents now living in community boarding houses or other types of homes. The chapter on child services is noteworthy because the Denver program has made sustained efforts in this high priority area to which only lip service is so often given. There is also a chapter on alcoholism, which describes the numerous problems inherent in building an adequate program.

A final chapter on area-wide planning points out that population mobility and the dispersed dwellings of most people do not fit with the concept of a geographic catchment area. However, Dr. Whittington does not suggest alternative approaches. Nor does he discuss citizen participation, to my disappointment.

The book is well written and makes its points with brevity. It fills a gap in a field relatively devoid of teaching texts and will be of interest to both professional and lay people. The book is a descriptive story in most part. Program evaluation is forthcoming, the editor says, but has not yet been achieved. However, he is encouraged by the Denver experience and is hopeful that community psychiatry is moving toward achieving its goals.

LUCY D. OZARIN, M.D.
Rockville, Md.

I'm OK—You're OK: A Practical Guide to Transactional Analysis, *by Thomas A. Harris, M.D. New York, Harper & Row, 1969, 267 pp., $5.95.*

I recall the consternation and the professional "explanations" when the smashingly successful Beatles arrived on the scene: "They appeal, through long hair and shaking, to bisexual tendencies"; "They offer 'release' from repression." Overlooked by many was that they were good, very good, extraordinarily good.

The same was true for tough Tony Galento, heavyweight prize fighter of East Orange, N.J. His form left a lot to be desired. He just kept coming in, punching, punching, punching—never stopping. Also good, very good.

I'm OK—You're OK, by Thomas A. Harris, M.D., has been in print since 1967. By now almost one million copies have been sold. Why so much interest? Why is this book "alive" six years later? Why is *I'm OK—You're OK* so widely read?

After a takeoff as long delayed—but in no way as gripping—as an overloaded 747 departing from a muddy runway on a hot day, the theme unfolds: In every person exists *P*arent-*A*dult-*C*hild, P-A-C for short. *P*arent is a combination of punishing superego, Jewish mother, "Uncle Sam wants you!" and a call from the bank about insufficient funds. *A*dult is old Jean Hirsholt as Dr. Christian, radio's Ma Perkins, and Senator William Fulbright. *C*hild, well, you have the idea. Also, the various possible combinations of "you and me," OK and Not-OK are reviewed—and the right answer is I'm OK—You're OK.

Dr. Harris makes it clear that the stakes are high, really high!

> Society cannot change until persons change. We base our hope for the future on the fact that we have seen persons change. How they have done it is the good news of this book. We trust it may be a volume of hope and an important page of the manual for the survival of mankind.

The basic words of Transactional Analysis (Parent, Adult, Child, NOT OK, OK, games, and stroking) are so simple that even if it were not possible to translate them into all other languages, they could be used as they are, with definitions in the words of those languages. "OK" is already an international word. *P*arent, *A*dult, and *C*hild could also become international words.

Yet, the sense of revealed truth aside, the book is sincere, dedicated, sometimes very wise, sometimes deeply touching. A section titled "Teaching P-A-C to the Retarded" is a particularly moving example of "P-A-C— I'm OK—You're OK" as a tool and philosophy for helping, rather than describing or explaining, human suffering.

En route, author-therapist Harris is revealed as a sincere, dedicated, humane clinician. His commitment to teaching P-A-C is personally intense for him—and undoubtedly inspiring for his patients.

Simple? Perhaps. Contrived? A bit. Naïve? Who knows? Still, Dr. Harris' and Dr. Berne's ideas have a unity to them. People can understand them. In Dr. Harris' hands they have a certain persuasiveness. Further, each person can "try it on for size" and use it if it works for him.

I enjoyed the book. I got something from it. I suspect that the 500,000 people who each told somebody else, "I'm OK—You're OK—it's OK—buy it" felt the same way.

MILTON H. MILLER, M.D.
Vancouver, British Columbia, Canada

This Month's Reviewers

HENRY P. LAUGHLIN, M.D., is in private practice in Bethesda, Md.

FREDERICK LEMERE, M.D., is Clinical Professor of Psychiatry, University of Washington School of Medicine, Seattle, Wash.

MORGAN MARTIN, M.D., is Superintendent, Norwich Hospital, Norwich, Conn.

MARIO VALENTE, M.D., is Adjunct Assistant Professor, Department of Psychiatry, Neuropsychiatric Institute, University of California at Los Angeles, Calif.

HENRY W. BROSIN, M.D., is Professor of Psychiatry, University of Arizona College of Medicine, Tucson, Ariz.

OSKAR DIETHELM, M.D., is with the Payne Whitney Psychiatric Clinic, New York, N.Y.

BARRIE S. GREIFF, M.D., is Lecturer in Occupational Psychiatry, Harvard Business School, Boston, Mass.

STUART M. FINCH, M.D., is Professor of Psychiatry, University of Michigan Medical School, Ann Arbor, Mich.

JOHN D. RAINER, M.D., is Professor of Clinical Psychiatry, Columbia University, New York, N.Y.

NATHAN SCHNAPER, M.D., is Clinical Associate Professor of Psychiatry and H. WILLIAM SCHNAPER is a medical student, University of Maryland School of Medicine, Baltimore, Md.

STANLEY L. BLOCK, M.D., is Director, Department of Psychiatry, Jewish Hospital, and Associate Professor, Department of Psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio.

FRANK J. MENOLASCINO, M.D., is Professor of Psychiatry and Pediatrics, University of Nebraska Medical Center, Omaha, Neb.

RAYMOND HEADLEE, M.D., is Clinical Professor of Psychiatry, Medical College of Wisconsin, and Professor of Psychology, Marquette University, Milwaukee, Wis.

REBECCA Z. SOLOMON, M.D. is in private practice; she is also Supervisor of Psychotherapy, Institute of Living, Hartford, Conn.

JOHN M. CALDWELL, M.D., is Professor Emeritus, University of Miami, Miami, Fla.

LUCY D. OZARIN, M.D., is Program Development Officer, Division of Mental Health Service Programs, National Institute of Mental Health, Rockville, Md.

MILTON H. MILLER, M.D., is Professor and Head, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia, Canada.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

The Murdering Mind, *by David Abrahamsen, M.D. New York, Harper & Row, 1973, 245 pp., $6.95.*

Dynamische Psychiatrie, *by Günter Ammon. Neuwied, Germany, Hermann Luchterhand Verlag, 1973, 263 pp., no price listed (paper).*

Hunger: A Biopsychological Analysis, *by Saul Balagura, M.D., Ph.D. New York, Basic Books, 1973, 174 pp., $8.95.*

Self-Discovery Through Self-Expression: Use of Art in Psychotherapy with Children and Adolescents, *by Mala Betensky, M.S.Sc., Ph.D. Springfield, Ill., Charles C Thomas, 1973, 394 pp., $13.95.*

Invisible Loyalties: Reciprocity in Intergenerational Family Therapy, *by Ivan Boszormenyi-Nagy, M.D., and Geraldine M. Spark, M.S.W. New York, Medical Department, Harper & Row, 1973, 392 pp., $12.50.*

Separation: Anxiety and Anger, vol. II of Attachment and Loss, *by John Bowlby. New York, Basic Books, 1973, 429 pp., $12.50.*

The Pleasure Areas: A New Theory of Behavior, *by H. J. Campbell. New York, Delacorte Press, Dell Publishing Co., 1973, 310 pp., $8.95.*

Retrolental Fibroplasia and Autistic Symptomatology, *by Joan B. Chase, Ed.D. New York, American Foundation for the Blind, 1973, 215 pp., $4.*

Outpatient Services: Journal Articles, *2nd ed., edited by Vivian Vreeland Clark, R.N., Ed.D. Flushing, N.Y., Medical Examination Publishing Co., 1973, 346 pp., $10 (paper).*

Nebraska Symposium on Motivation, 1972, *edited by James K. Cole and Donald D. Jensen. Lincoln, University of Nebraska Press, 1973, 333 pp., $4.25 (paper).*

Colloque: Activités Evoquées et leur Conditionnement chez l'homme normal et en pathologie mentale, 1972. *Paris, Institut National de la Santé et de la Recherche Médicale, 1973, 447 pp., 50F (paper).*

The Economics of Mental Retardation, *by Ronald W. Conley. Baltimore, Johns Hopkins University Press, 1973, 372 pp., $15.*

The Hamadsha: A Study in Moroccan Ethnopsychiatry, *by Vincent Crapanzano. Berkeley, University of California Press, 1973, 248 pp., $12.*

The Malpractice of Psychiatrists, *by Donald J. Dawidoff. Springfield, Ill., Charles C Thomas, 1973, 145 pp., $9.75.*

Potential: The Way to Emotional Maturity, *by Hugh Downs. New York, Doubleday & Co., 1973, 222 pp., $6.95.*

The Psychology of Adult Development and Aging, *edited by Carl Eisdorfer and M. Powell Lawton. Washington, D.C., American Psychological Association, 1973, 708 pp., $11 (paper).*

Psychoanalytic Psychology: The Development of Freud's Thought, *by Raymond E. Fancher, Ph.D. New York, W.W. Norton & Co., 1973, 233 pp., $8.95.*

The Birth of the Clinic: An Archaeology of Medical Perception, *by Michel Foucault, translated by A.M. Sheridan Smith. New York, Pantheon Books, Random House, 1973, 209 pp., $8.95.*

Annual Review of Behavior Therapy: Theory & Practice, 1973, *edited by Cyril M. Franks, Ph.D., and G. Terence Wilson, Ph.D. New York, Brunner/Mazel, 1973, 817 pp., $25.*

A Time for Remembering, *by Joseph Garland, M.D. Boston, New England Journal of Medicine, 1972, 203 pp., $6.50.*

The Human Circle: An Existential Approach to the New Group Therapies, *by Carl Goldberg, Ph.D., with Merle Canton Goldberg, M.S.W. Chicago, Nelson-Hall Co., 1973, 246 pp., $12.*

The Inevitability of Patriarchy, *by Steven Goldberg. New York, William Morrow & Co., 1973, 245 pp., $6.95.*

Alcohol Intoxication and Withdrawal: Experimental Studies, *edited by Milton M. Gross. New York, Plenum Publishing Corp., 1973, 413 pp., $24.*

Approaches to the Mind, *by Leston L. Havens, M.D. Boston, Little, Brown and Co., 1973, 361 pp., $10.*

Clinical Use of Psychotherapeutic Drugs, *by Leo E. Hollister, M.D. Springfield, Ill., Charles C Thomas, 1973, 185 pp., $6.95.*

Index to Literature on the American Indian: 1971. *San Francisco, Indian Historian Press, 1972, 230 pp., $12 (paper).*

Index to Literature on the American Indian: 1970. *San Francisco, Indian Historian Press, 1972, 177 pp., $12 (paper).*

Brain Damage and Mental Retardation: A Psychological Evaluation, *2nd ed., edited by J.L. Khanna, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 210 pp., $8.75.*

Adolescent Immaturity: Prevention and Treatment, *by I. Newton Kugelmass, M.D., Ph.D., Sc.D. Springfield, Ill., Charles C Thomas, 1973, 307 pp., $12.50.*

The Origin and Treatment of Schizophrenic Disorders, *by Theodore Lidz, M.D. New York, Basic Books, 1973, 137 pp., $6.95.*

In Search of Nixon: A Psychohistorical Inquiry, *by Bruce Mazlish. Baltimore, Penguin Books, 1973, 182 pp., $1.50 (paper).*

Children in Play Therapy *(reprint), by Clark Moustakas, Ph.D.*

New York, Jason Aronson, 1973, 213 pp., $10.

Foundations of Psychopathology, *2nd ed., by John C. Nemiah, M.D. New York, Jason Aronson, 1973, 328 pp., $12.50.*

The Walking Patient and the Health Crisis, *by Charles G. Oakes. Columbia, University of South Carolina Press, 1973, 416 pp., $9.95.*

The Effects of Hospitalization on Children: Models for Their Care, *edited by Evelyn K. Oremland, M.S.W., and Jerome D. Oremland, M.D. Springfield, Ill., Charles C Thomas, 1973, 333 pp., $12.75.*

Experiment, Design and Statistics in Psychology, *by Colin Robson. Baltimore, Penguin Books, 1973, 170 pp., $3.45 (paper).*

The Mental Hospital Nightmare, *by Louella Sturm. Jericho, N.Y., Exposition Press, 1973, 62 pp., $4.*

Accident or Suicide? Destruction by Automobile, *edited by Norman Tabachnick, M.D. Springfield, Ill., Charles C Thomas, 1973, 254 pp., $11.95.*

Task Force Report 6: The Present and Future Importance of Patterns of Private Psychiatric Practice in the Delivery of Mental Health Services. *Washington, D.C., American Psychiatric Association, 1973, 29 pp., $2 (paper).*

The Mental Retardation Dic·tion·ar·y, *by Alexander J. Tymchuk, Ph.D. Los Angeles, Western Psychological Services, 1973, 112 pp., $6.50 (paper).*

Dream Telepathy: Scientific Experiments in the Supernatural, *by Montague Ullman, M.D., and Stanley Krippner, Ph.D., with Alan Vaughan. New York, Macmillan Co., 1973, 286 pp., $8.95.*

Sleep Research and Clinical Practice, *edited by Gene Usdin, M.D. New York, Brunner/Mazel, 1973, 94 pp., $6.*

Mental Health Care in the World of Work, *by Hyman J. Weiner, Sheila H. Akabas, and John J. Sommer. New York, Association Press, 1973, 182 pp., $8.95.*

How People Change, *by Allen Wheelis. New York, Harper & Row, 1973, 117 pp., $5.*

The Moralist, *by Allen Wheelis. New York, Basic Books, 1973, 159 pp., $7.95.*

To Live and To Die: When, Why, and How, *edited by Robert H. Williams. New York, Springer-Verlag, 1973, 346 pp., no price listed.*

The Power Motive, *by David G. Winter, Ph.D. New York, Free Press, Macmillan Co., 1973, 362 pp., $12.*

OFFICIAL ACTIONS

Report of the Secretary: Summary of Meetings of Board of Trustees and Executive Committee May 1972–May 1973

IT IS MY PRIVILEGE to report for your information and approval the actions of the Board of Trustees since the last annual meeting. At the conclusion of this report I shall request your ratification of the actions. The Board of Trustees has approved these actions now presented to you, the members.

Most Board actions result from specific recommendations from the committees—recommendations that may originate in a specific committee or result from study and investigation of a problem referred to a particular committee. Recommendations for action also come to the Board from the Assembly of District Branches.

Referrals to committees or individuals are not included in this report since they are being investigated or studied for recommendation to the Board at a later date. Also omitted are the various presidential appointments reported to the Executive Committee and to the Board throughout the year.

I would like to call to your attention the fact that in order to keep the membership informed of developments and new policies, it has for several years been the custom to circulate minutes of each Board of Trustees and Executive Committee meeting to the president, secretary, and delegate of each district branch. In addition, the branches are invited to send representatives to each meeting of the Board; these representatives are always welcome.

For my report, I have divided the actions into several categories, beginning with fiscal matters. In these actions the Board (or the Executive Committee acting as its agent):

FISCAL MATTERS

1. Reaffirmed authorization for an expenditure of up to $200,000 for purchase of a site for expansion of APA headquarters, and noted further the availability of $1,000,000 for the construction and furnishing of the additional space required (Ex.C., June '72).

2. Noted the intention to accumulate a surplus of funds sufficient to defray the operating expenses of APA for one year (Ex.C., June '72).

3. Authorized the Medical Director to employ whatever legal services are necessary to fight the unrelated income tax ruling of the Internal Revenue Service (Ex.C., June '72).

4. Authorized setting aside $1,000 from funds remaining in the pooled councils' balance to print 3,000 copies of a *1972 National Directory of Providers of Psychiatric Services to Religious Institutions* if the Council on Professions and Associations cannot absorb all the cost (Ex.C., Sept. '72).

5. Authorized expenditure of up to $10,000 to hold an additional special ad hoc meeting of the Board of Trustees for policy discussions (Ex.C., Sept. '72).

6. Approved restoring $5,000 to the 1973 annual meeting budget to provide for shuttle bus service in Hawaii (Bd., Dec. '72).

7. Approved and accepted the entire budget for fiscal year 1973–1974, including the one change noted regarding increase in the membership fees for the Council of Medical Specialty Societies (Bd., Dec. '72).

8. Approved increasing the travel budget for area council meetings of the Assembly of District Branches from $5,000 a year to $8,500 a year (Bd., Dec. '72).

9. Approved increasing the budget of the AMA Section Council on Psychiatry from $350 to $3,500—to reflect the wish of the Board of Trustees in its April 1972 meeting that an interim meeting of the Section Council be authorized for a two-year trial (Bd., Dec. '72).

10. Approved expenditure of $12,558 from the accumulated proceeds of the Second Psychiatric Knowledge Self-Assessment Program (PKSAP-II) to fully fund salaries and pay additional office expenses of the Office of Continuing Education for Psychiatrists for its operation during the year (Ex.C., Sept. '72).

11. Approved use of funds as they accumulate (over and above the $12,558) from receipts of the PKSAP-II, up to the amount of $59,000, for the research phase of the project, but recommended to the director of the Office of Continuing Education for Psychiatrists that he try to find other sources of funding—either private foundations or different approaches to government funding (Ex.C., Sept. '72).

12. Declined a request to authorize the expenditure of up to $7,000 in connection with expanded operations of the Government Relations Section and encouraged the district branches to hold their own area meetings of legislative representatives (Ex.C., Sept. '72).

13. Authorized a loan of $151,815 as requested by the American Psychiatric Museum Association, Inc., in December 1971 for its fiscal year, Oct. 1, 1972, to Sept. 30, 1973. (Noted approval of budget estimate of Museum expenses for 1973–1974 in the amount of $166,723.) (Bd., Dec. '72)

14. Approved adding $5,000 to the Museum budget for part-

This is an edited version of the report presented by the Secretary at the annual business meeting in Honolulu, Hawaii, May 8, 1973.

time and temporary help (Bd., Dec. '72).

15. Authorized an expenditure of up to $30,000 for supplementary expenses of the Manpower Research and Development Division, to cover items as presented by the Treasurer: 1) to complete coding and analysis of responses to the 1970 APA census of psychiatrists; 2) to pay a systems design analyst to advise on the operation of the system and its redesign; and 3) supplementary costs for securing data not obtained in the February survey. This data will also make possible a directory of residency training centers (Bd., Dec. '72).

16. Reaffirmed a mail vote of the Executive Committee in favor of drawing up a contract to fund the revised computer program of the Manpower Research and Development Division and its national retrieval system (Ex.C., Feb. '73).

17. Denied a request for a $7,000 appropriation to the Physician Education Project, for additional staff (Ex.C., Feb. '73).

18. Authorized withdrawing $36,000 from investments for deposit in the miscellaneous financial expense account, in order that APA employees may receive a five percent salary increase on April 1, 1973 (Ex.C., Feb. '73).

19. Authorized an extra $500 from the Board of Trustees Contingency Fund to cover APA's increased share of costs, from $2,500 to $3,000 per year, for the Joint Commission on Accreditation of Hospitals (JCAH) Accreditation Council for the Facilities for the Mentally Retarded (Ex.C., Sept. '72).

20. Authorized payment of $1,932 in dues, for APA's share of costs for one year, to the Council of Medical Specialty Societies, for input into the medical policy body—money to come from the Board of Trustees Contingency Fund (Ex.C., Sept. '72).

21. Disapproved a request to lend $20,000 to an unnamed refugee colleague as being against APA policy (Ex.C., Sept. '72).

22. Approved APA's acting as fiscal and administrative agent for the American Association of Psychiatric Services to Children through January 1, 1973, at a monthly service charge of $100, and noted receipt of a $6,000 check for initial expenses (Ex.C., Sept. '72).

23. Authorized funds to cover the increase in cost for a seat on the JCAH Accreditation Council for Psychiatric Facilities from $2,716 a seat to $3,000 a seat—or an increase of $852 for APA's three seats on the Council (Bd., Dec. '72).

24. Authorized expenditure of up to $500 for a breakfast meeting with members of Congress and their staff members, the funds to come from the short-term investment account (Ex.C., Feb. '73).

25. Denied a request from the student AMA representative for travel subsidy to the APA annual meeting in Hawaii (Ex.C., Feb. '73).

26. Denied a request for funds from the National Conference on Citizenship (Ex.C., Feb. '73).

27. Authorized a $1,000 contribution to the Coalition for Health Funding, to assist with salary, postage, materials, duplicating, and other expenses of maintaining its office (Ex.C., Feb. '73).

28. Took no action to grant a contribution for support of a research project by the Foundation of the American Society of Association Executives, Inc., or for two other specific requests for contributions—from the National Council on Aging and the National Council on Alcoholism (Ex.C., Feb. '73).

29. Requested the Budget Committee to review the whole policy of contributions to other organizations and to come up with a standard rule (Ex.C., Feb. '73).

30. Authorized the Medical Director to file a grant proposal on the development of action-oriented recommendations that would lead to a more favorable distribution of psychiatrists in relation to the needs of four populations: rural, poverty, minority, and the seriously mentally ill (Ex.C., June '72).

31. Authorized the American Psychiatric Museum Association, Inc., to file a grant application for $60,000 on behalf of the APA Commission on History, to develop a project on the Oral History of United States Psychiatric Achievement, 1938–1970 (Ex.C., June '72).

32. Authorized the Task Force on Indian Affairs to negotiate a one-year contract of $25,000 with the Indian Health Service for a study of mental health problems among Indians (Ex.C., June '72).

33. Authorized the Council on International Affairs to seek funds from outside sources in support of the Second Inter-American Congress on Mental Health of Children and Youth, to be held in Puerto Rico, Sept. 28–Oct. 3, 1973 (Bd., Dec. '72).

34. Authorized the Task Force on Psychiatric Involvement in Family Planning to seek outside funding to plan and conduct a conference on the psychosocial and psychocultural aspects of family planning (Bd., Dec. '72).

35. Authorized the Task Force on Family Life Education to seek outside funding for a national conference to promote mutual understanding of the roles of psychiatrists and other professionals in family life education (Bd., Dec. '72).

36. Authorized the Medical Director to seek a grant from NIMH jointly with Mr. James Mitchell of the Advanced Study Section of the Brookings Institution to support another public policy conference jointly sponsored by APA and the Brookings Institution (Ex.C., Feb. '73).

37. Approved APA's endorsement of an application for a grant by the department of psychiatry at Harvard University to the National Library of Medicine to produce films on emergency psychiatric services, with the understanding that the APA seal of sponsorship not appear on the film unless the final product has been reviewed and approved (Ex.C., Feb. '73).

MEMBERSHIP MATTERS

1. Reaffirmed the intent of the Constitution and By-Laws that a member dropped by either APA or a district branch may not be a member of the other group (Ex.C., Sept. '72).

2. Dropped from APA membership 57 members who were three years in arrears in dues as of March 31, 1972, who had been extended until September, and who had not responded to repeated efforts to collect (Ex.C., Sept. '72).

3. Took individual actions in the cases of 13 other members who had been listed as three years in arrears in dues as of March 31, 1972 (Ex.C., Sept. '72).

4. Endorsed the Assembly's approval of the recommendation of the Commission on Future Planning that there be no new class of membership in APA at this time (Bd., Dec. '72).

5. Endorsed the Assembly recommendation for family membership in APA, with dues at the rate of 150 percent of individual membership, and referred the matter to the Membership Committee for consideration (Bd., Dec. '72).

6. Rescinded the action taken by the Executive Committee in September 1972 of dropping nine members who had since paid dues that were previously three years in arrears (Bd., Dec. '72).

7. Individual actions on the membership status of others were taken or postponed, as recommended by the Membership Committee (Bd., Dec. '72).

8. Accepted the recommendation of the Committee on Membership and, waiving the requirement of a five-year general membership, elevated Dr. H. Keith H. Brodie to the status of Fellow in APA, as of May 1973 (Ex.C., Feb. '73).

9. Rescinded a previous dropping action in a case where all back dues have now been paid, in accordance with the recommendation of the Membership Committee (Ex.C., Feb. '73).

BALLOTING

1. Approved individual suggestions made by Executive Committee members for changes in the body of the report of the Ad Hoc Committee on Election Procedures (Ex.C., Sept. '72).

2. Accepted the report of the Ad Hoc Committee on Election Procedures and dissolved the committee (Ex.C., Sept. '72).

3. Considered the Ad Hoc Committee on Election Procedures' suggested addition to the section on balloting regarding plurality of votes when three or more candidates run for one office (Ex.C., Sept. '72, and Bd., Dec. '72).

4. Referred the question of election by majority to the Assembly, with a definite charge to contact the district branches with the specific question, "Do you approve election by plurality or majority?" (Ex.C., Feb. '73)

5. Approved the proposal of the Ad Hoc Committee on Election Procedures, as recommended by the Assembly's Executive Committee, that in the event district branches who choose to campaign within their jurisdictional areas require financial support for such campaigning, such financial support be supplied by solicitation of voluntary funding, and that in no case dues be utilized for campaigning purposes (Ex.C., Feb. '73).

CONFERENCES

Approved holding a second Institute on Government Operations in March 1973, approved accepting of a $5,000 grant from Smith Kline & French to fund faculty and administrative costs, and approved setting aside $3,600 in APA funds from the valuation reserve account for the Institute ($2,000 for implementation of the meeting itself and $1,600 for a meeting of the steering-planning committee), to supplement the funds of Smith Kline & French (Ex.C., Sept. '72).

PUBLICATIONS

1. Approved publication of a summary of APA position statements from 1948 to 1972, *Official Position Statements of APA in Précis Form* (Ex.C., Sept. '72).

2. Authorized staff to seek methods of underwriting the cost of wider distribution of *Prospects and Proposals: Lifetime Learning for Psychiatrists* (Bd., Dec. '72).

3. Approved publication of a *Position Statement on Peer Review in Psychiatry*, the document submitted by the Task Force on Peer Review and cleared by the Assembly (Bd., Dec. '72).

4. Asked the Division of Public Affairs to publish, with the help of an advisory committee, a pamphlet on the rights of the mentally ill and mentally retarded consumer (Bd., Feb. '73).

5. Approved, as amended, the proposed recruiting pamphlet for residents in training, which will be issued under the title *We're Involved! Are You?* (Ex.C., Feb. '73)

6. Asked the President to appoint a subcommittee of the Board of Trustees to review the document being prepared on alternate methods of funding residency training, in addition to final review and approval by the Advisory Committee—Project to Develop Alternatives to Funding of Psychiatric Residency Training (Ex.C., Feb. '73).

POSITION STATEMENTS AND RESOLUTIONS

1. Accepted the Report of the Task Force on the Status of State Psychiatric Hospitals for printing in an Association publication (Ex.C., June '72).

2. Approved the Assembly resolution recognizing the psychiatrist's office as a legitimate psychiatric facility (Ex.C., June '72).

3. Approved in principle the Assembly resolution providing that all position statements be reviewed by the Assembly before presentation as official policy of APA, contingent upon the Executive Committee of the Assembly's developing a satisfactory mechanism for implementation (Ex.C., June '72).

4. Approved the Assembly's position statement, "National Health Insurance—A Statement of Principles" (Ex.C., Sept. '72).

5. Approved the position statement developed by the Task Force on Interprofessional Relations ("Position Statement on Psychiatrists' Relationships with Nonmedical Mental Health Professionals"), which had been cleared by the Assembly (Bd., Dec. '72).

6. Approved a position statement developed by the Committee on Psychiatry and the Law, at the request of the Assembly: "Position Statement on Involuntary Hospitalization of the Mentally Ill (Revised)" (Bd., Dec. '72).

7. Approved the "Position Statement on College Mental Health," as recommended by the Assembly (Ex.C., Feb. '73).

8. Approved the "Position Statement on the Confidentiality of Medical Research Records," as developed by the APA Task Force on the Confidentiality of Medical Research Records and approved by the Assembly (Ex.C., Feb. '73).

9. Approved the "Position Statement on Aging" (Ex.C., Feb '73).

10. Approved an Assembly resolution (from Area V) that insurance carriers utilized by APA be only those who are able to clearly demonstrate high levels of performance in promoting the concept of the insurability of psychiatric illness and in protecting the interests of the patient (Bd., Dec. '72).

11. Approved an Assembly resolution recommending that strong controls be placed on the availability of all types of guns and rifles—with particular consideration to a policy of confiscation of hand weapons—and allowing for safeguards for retention of appropriate weapons by those with clearly defined requirements for such weapons (Bd., Dec. '72).

12. Approved the "Joint Statement on Antisubstitution Laws and Regulations," as requested by AMA. It was planned that the statement be published in a forthcoming issue of *The American Journal of Psychiatry* (Ex.C., Feb. '73).

ANNUAL MEETING

1. Accepted Toronto as the site for the annual meeting in 1977 (May 9–13), with the staff to investigate any deterrents to achievement of this goal, but asked that the option of Dallas be held open as the next desired place (Bd., Dec. '72).

2. Accepted New Orleans as the site for the annual meeting in 1981 (May 10–15) (Bd., Dec. '72).

3. Approved many recommendations of the Committee on Conventions for revision of the *APA Procedure and Policy Manual for Annual Meetings* (Bd., Dec. '72).

4. Approved the recommended schedule for the 1973 annual meeting in Hawaii, with one exception: disapproved eliminating the presidential reception after the opening session (Bd., Dec. '72).

5. Approved revisions in regulations for operation of the

grants and awards program—mainly clarification of existing policy (Bd., Dec. '72).

AWARDS

1. Approved the selection of an outstanding person in the field of continuing education (Raymond Feldman, M.D.) to receive the 1973 Vestermark Award; approved the change in the format for this year as recommended by the Reference Committee; and approved the recommendation that the future format and criteria for the Vestermark Award be studied by the Grants and Awards Committee (Ex.C., Sept. '72).

2. Approved the Nominating Committee's recommendation that qualifications for nomination for the Distinguished Service Award be publicized in *Psychiatric News* and *The American Journal of Psychiatry* (Bd., Dec. '72).

3. Approved broadening the scope of the Distinguished Service Award, to recapture the original 1964 intent to make it "a citation for highly meritorious service to American psychiatry," to be awarded at the annual meeting in those years when such citation is merited; and further specified that the responsibility for selection of candidates remain with the Nominating Committee (Bd., Dec. '72).

4. Approved the Membership Committee's selection of Martin Roth, M.D., Newcastle-on-Tyne, England, as Distinguished Fellow (Bd., Dec. '72).

5. Approved the Membership Committee's selection of George Anthony Vassiliou, M.D., Athens, Greece, as Corresponding Fellow (Bd., Dec. '72).

6. Approved the Membership Committee's selection of Wesley Arthur Pomeroy, LL.B., J.D., Washington, D. C., as Honorary Fellow (Bd., Dec. '72).

BOARD OF TRUSTEES AND EXECUTIVE COMMITTEE

1. Approved Ewald W. Busse, M.D., as a member of the APA Executive Committee (Bd., May '72).

2. Approved Melvin Sabshin, M.D., as a member of the APA Executive Committee (Bd., May '72).

3. Elected Harry H. Brunt, M.D., to fill the unexpired term of Robert W. Gibson, M.D., on the APA Board of Trustees (Bd., May '72).

4. Voted to hold an additional special ad hoc meeting of the Board of Trustees for policy discussions; limited attendance to voting members of the Board; and noted that it would probably be held in February 1973—definite time, site, and program content to be decided later (Ex.C., Sept. '72).

5. Approved inviting the full Board of Trustees to participate in the special February policy meeting and making this meeting a regular instead of ad hoc meeting (Ex.C., Oct. '72).

6. Extended congratulations to the Program Committee for the special policy meeting of the Board of Trustees in Atlanta, Ga., Feb. 2 and 3, 1973 (Bd., Feb. '73).

7. Asked the President to appoint whatever he deems an appropriate number of Board members to a joint committee with members of the Committee on Constitution and By-Laws and the Executive Committee of the Assembly, to study the issues concerning governance of the Association and representation of the membership on the Board of Trustees (Ex.C., Feb. '73).

8. Asked the Committee on Constitution and By-Laws to consider whether representation on the Board of Trustees should be by subspecialty of interest or solely on the basis of geography (Bd., Feb. '73).

9. Approved holding an extra Executive Committee meeting on April 16, 1973, prior to the May 1973 meeting of the Board of Trustees, to hear the reports that normally take up most of the Board's regularly scheduled two-day meeting in May (Bd., Feb. '73).

10. Approved the request that the Executive Committee schedule its meetings often enough to take care of routine matters of APA business, thereby freeing the Board for more substantive matters and to carry out its primary function of formulating and implementing the policies of the Association (Bd., Feb. '73).

ASSEMBLY

1. Approved the petition for the establishment of a district branch in New Mexico, to be known as the New Mexico Psychiatric Association (Ex.C., June '72).

2. Received the resolution of the Assembly requesting establishment of a research project to study the development of care of the mentally ill by the private sector of psychiatry, and asked that the Assembly be informed as to what direct and pertinent action is being taken at the present time relevant to this matter (Ex.C., June '72).

3. Authorized the Executive Committee of the Assembly to appoint an assembly delegate as a member to attend meetings of each council, to improve communication between the Assembly and the Reference Committee (Bd., Feb. '73).

4. Approved in principle the policy of transmitting Reference Committee reports of the councils simultaneously to the Assembly and the Board of Trustees, to minimize delay in obtaining reactions to reports. Recognizing that this may sometimes be an unmanageable procedure, the Board asked that it be implemented whenever feasible (Bd., Feb. '73).

5. Encouraged the Assembly to ask district branches to function in an advocacy role in their own local areas and to work in conjunction with other consumer advocate bodies (Bd., Feb. '73).

6. Approved the recommendation that the Assembly's Executive Committee liaison appointee to the Council on Internal Organization be responsible for collaboration between the Assembly and the Committee of Residents (Ex.C., Feb. '73).

7. Accepted the Assembly Executive Committee's recommendation to approve an amendment to Article IX, Section 7, of the *Procedural Code*, to give the officers and voting members of the Board of Trustees one vote each, inasmuch as they represent the total membership of the Association (Ex.C., Feb. '73).

8. Rescinded the action (immediately above) taken by the Executive Committee on February 23, 1973, noting that it was doubtful that the Board should vote in this situation in view of its constitutional power to review actions (Ex.C., Apr. '73).

COUNCILS, COMMITTEES, TASK FORCES, AND COMMISSIONS

1. Accepted the recommendation that a task force be established for review of APA *Standards for Psychiatric Facilities*, with priority given to those standards relevant to the Alabama court decision concerning right to treatment (Ex.C., June '72).

2. Approved the request by the chairman of the Council on Internal Organization that his group have available the cost analysis information on the physicians' liability study for further discussion at the October meetings, and left it tabled for the time being (Ex.C., Sept. '72).

3. Terminated two committees: Committee on Rehabilitation and Committee on Psychiatry and Social Work (Bd., Dec. '72).

4. Approved replacing the current Commission on Manpower (scheduled to terminate in May 1973) with an advisory group to the Division of Manpower Research and Development; for purposes of administration and funding the group will be assigned to the Council on Mental Health Services (Bd., Dec. '72).

5. Approved replacing the current Task Force of Residents (scheduled to terminate in May 1973) with a Committee of Residents (or young members), to be assigned to the Council on Internal Organization and to work collaboratively with appropriate components of the Assembly (Bd., Dec. '72).

6. Instructed the Reference Committee to develop before May a structured form for use in delineating the objectives, time limitations, and procedures for achieving the task assigned to each task force, committee, and commission of APA (Bd., Feb. '73).

7. Extended the Commission on Childhood and Adolescence for three years, until May 1976 (Ex.C., Feb. '73).

8. Extended the Commission on Drug Abuse for three years, until May 1976 (Ex.C., Feb. '73).

9. Approved continuance of observer/consultant appointments to each council, with tenure not to exceed five years and possibly to be less than that, to allow for more appointments (Ex.C., Feb. '73).

10. Approved the Assembly's recommendation that final action on *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* be delayed until the May meeting of the Board of Trustees, and asked that in the interim suggested changes (by the Board at this meeting and those subsequently made by district branches and area councils) be reported to the Assembly Executive Committee in February, for recommendation back to the Board of Trustees in May 1973 (Bd., Dec. '72).

11. Approved the proposed policy for maintaining ethical records and asked that legal counsel advise on the period records should be retained before old files are destroyed (Ex.C., Feb. '73).

12. Accepted the Nominating Committee's slate of nominees for officers and trustees for the 1973 APA election and approved the committee's selection for the recipient of the Distinguished Service Award (Bd., Dec. '72).

13. Approved the recommendations of the Committee on Constitution and By-Laws with regard to tightening up the procedures for forming the Nominating Committee from panels presented by the area councils (Bd., Dec. '72).

14. Approved the Nominating Committee's recommendation that a confidential historical file be compiled and maintained in the central office for the continuing guidance of future Nominating Committees (Bd., Dec. '72).

15. Approved the recommendation that area councils publicize the methods of choosing Nominating Committee members, so that members may know their obligations prior to the Nominating Committee's meeting (Ex.C., Feb. '73).

16. Approved continuation of the Ad Hoc Committee on Election Procedures and the Ad Hoc Committee to Study Use of Psychiatric Facilities for Commitment of Political Dissenters for one more year (Bd., May '72).

17. Authorized the Ad Hoc Committee to Study Use of Psychiatric Facilities for Commitment of Political Dissenters to seek necessary funds to finance a project of seeking out and researching examples of specific problems for study (Ex.C., June '72).

18. Approved changing the name of the Ad Hoc Committee to Study Use of Psychiatric Facilities for Commitment of Political Dissenters to that of Ad Hoc Committee to Study Conflicts Inherent in the Therapeutic and Institutional Roles of Psychiatry, but urged constraint in the focus of the mission (Ex.C., Sept. '72).

19. Authorized $2,000 from the pooled balance in Council funds to help finance four proposed meetings this year of the Ad Hoc Committee to Study Conflicts Inherent in the Therapeutic and Institutional Roles of Psychiatry, and recommended that the committee use $2,000 of its grant money for any additional money needed, instead of hiring a principal investigator immediately (Ex.C., Sept. '72).

20. On recommendation of the chairman, disbanded the Ad Hoc Committee to Study Conflicts Inherent in the Therapeutic and Institutional Roles of Psychiatry and requested the Council on Research and Development to appoint a task force to consider the whole matter (Bd., Feb. '73).

21. Authorized the Medical Director to negotiate with the Grant Foundation for payment of debts incurred by the Ad Hoc Committee to Study Conflicts Inherent in the Therapeutic and Institutional Roles of Psychiatry (Bd., Feb. '73).

CONSTITUTION AND BY-LAWS

1. Approved the recommendation of the Committee on Constitution and By-Laws that both the Secretary and Treasurer be elected for two-year terms (in alternate years) and that they be allowed to succeed themselves in office (Bd., Dec. '72).

2. Rejected the recommendation of the Committee on Constitution and By-Laws to eliminate the offices of Vice-President, but favored their terms being increased from one to two years, with elections in alternate years (Bd., Dec. '72).

3. Recommended to the Committee on Constitution and By-Laws that the Trustee-at-Large position be retained (Bd., Dec. '72).

4. Approved the recommendation of the Committee on Constitution and By-Laws that it be mandatory for members to participate in continuing education programs, in accordance with standards to be set by the Association (Bd., Dec. '72).

5. Reaffirmed the position that Vice-Presidents be elected for two-year terms, taking office in alternate years. It was further decided that in order to activate this system if adopted, the candidate receiving the larger number of votes in the first election would be the first two-year Vice-President (Ex.C., Feb. '73).

6. Voted to retain the Trustee-at-Large position on the Board of Trustees (Ex.C., Feb. '73).

7. Voted to retain one Trustee from each designated area of APA—as presently provided in the Constitution—on the Board of Trustees (Ex.C., Feb. '73).

8. Voted to retain a three-year term of office for area Trustees on the Board of Trustees (Ex.C., Feb. '73).

9. Favored retaining the status quo on Past Presidents—that their tenure on the Board of Trustees remain unchanged (Ex.C., Feb. '73).

LIAISON WITH OTHER ORGANIZATIONS

1. Nominated Milton Greenblatt, M.D., for another four-year term as APA director on the American Board of Psychiatry and Neurology, Inc. (Bd., May '72).

2. Nominated Marc Hollender, M.D., as a director on the American Board of Psychiatry and Neurology, Inc., to fill the unexpired term of Lester Rudy, M.D., who assumed the post of executive secretary-treasurer of the ABPN (Ex.C., June '72).

3. Approved a recommendation that APA again request the American Board of Psychiatry and Neurology, Inc., to consider

responsibility for certification in administrative psychiatry (Bd., Dec. '72).

4. Noted and approved forwarding without comment two suggestions of the Council on Medical Education and Career Development regarding consumer representation on the American Board of Psychiatry and Neurology, Inc. (Bd., Dec. '72).

5. Approved conveying without comment the recommendation of the Council on Medical Education and Career Development that training in drug abuse and alcoholism be made a requirement of all residency training programs (Bd., Dec. '72).

6. Approved the suggestion from the American Board of Psychiatry and Neurology, Inc., that Part I, the written examination, may be taken following residency training and that the oral examination may be taken two years later (Ex.C., Feb. '73).

7. Authorized the Medical Director to develop a temporary mechanism for recommending to the AMA accreditation of such allied health workers as corrective therapists, art therapists, and mental health technicians (Ex.C., June '72).

8. Authorized APA headquarters to act as resident agent for the World Psychiatric Association in the District of Columbia, upon written request from the president and the board (or equivalent body) of that group to do so (Ex.C., June '72).

9. Approved the constitution of the Inter-American Council on Psychiatric Associations as submitted (Ex.C., June '72).

10. Approved sending an APA representative to participate in the planning and project proposal of the National Council of Community Mental Health Centers, and authorized funds for his attendance at the meetings (Ex.C., Sept. '72).

11. Approved collaboration with the Royal College of Psychiatrists in a medical education project via closed-circuit television (Ex.C., Sept. '72).

12. Requested the Medical Director to explore a possible basis for affiliation in some form with the American Board of Qualification in Electroencephalography (Ex.C., Feb. '73).

13. Authorized the Medical Director to invite the People's Republic of China to send a representative to participate in any appropriate APA annual meeting—possibly Hawaii in 1973 or Detroit in 1974 (Ex.C., Feb. '73).

OTHER

1. Authorized a telegram to the New York Assembly opposing the separation of mental health from mental hygiene in New York State (Bd., May '72).

2. Received the preliminary report on the member motivation study, with the proviso that the Trustees receive whatever else Prof. Laurence Williams may have in the way of information, and voted to take no further action to extend the study at this time (Ex.C., Sept. '72).

3. Accepted with pleasure the gift from the Gralnick Foundation of a portrait of Austin Davies (Bd., Dec. '72).

4. Approved and endorsed the *AJP* Editorial Board's nominations for three new members: Drs. H. Keith H. Brodie of California, John M. Davis of Tennessee, and Rebecca Z. Solomon of Connecticut (Bd., Dec. '72).

5. Approved the Medical Director's absence from headquarters for approximately four weeks in order to participate in a trip by a 15-member delegation to the People's Republic of China (Ex.C., Feb. '73).

6. Authorized the Task Force of Residents' use of a column in *Psychiatric News*, with the understanding that it be in conformance with APA editorial policy (Ex.C., June '72).

7. Reiterated the request that ways be found to implement the action of the Board of Trustees in its April 29–30, 1972, meeting to increase the function and personnel of the central office's Government Relations Section (Bd., Feb. '73).

8. Requested a study of the feasibility of establishing an office of consumer advocacy or education on the order of the Physician Education Project, with an advisory committee to work with it, and asked for a report at the May 1973 meeting of the Board of Trustees (Bd., Feb. '73).

9. Recommended that the Council on Medical Education and Career Development study the physiomedical aspects of psychiatry and ways in which the residency may be modified (Ex.C., Feb. '73).

10. Approved in principle the new professional liability insurance program for APA members, to be administered by the Joseph A. Britton Agency, subject to approval of the final policy by APA legal counsel, in collaboration with the Committee on Insurance (Ex.C., June '72).

11. Approved three recommendations of the Committee on Member Insurance and Retirement, providing that: 1) committee members be retained for more than one term; 2) authority be given the committee to invite an occasional consultant versed in the malpractice situation; and 3) authority be given the APA President to appoint additional members to the committee if the work load warrants it (Bd., Dec. '72).

12. Considered the resolution on the California confidentiality case involving Dr. George R. Caesar and defeated a motion to donate $2,500 in support of an appeal to the Appellate Court (Bd., May '72).

13. Unanimously disapproved a general policy of financial participation in the defense of psychiatrists who become involved in cases to protect patients' rights of confidentiality (Ex.C., June '72).

14. Approved joining in amicus curiae briefs in the case of *Wyatt v. Stickney* (right to treatment) (Bd., Dec. '72).

15. Validated an affirmative vote in a conference call of March 6, 1973, that APA should file an amicus curiae brief in the case of *Anonymous v. Rogers* (confidentiality of medical records) (Ex.C., Apr. '73).

16. Directed the Council on Medical Education and Career Development to study Dr. E.W. Busse's recommendation for participation in continuing education as a requirement of membership and to bring back a recommendation to the December 1972 meeting of the Board of Trustees (Ex.C., June '72).

17. Approved the Assembly's recommendation that APA devise its own procedure by which district branches can obtain approval for and provide credit to those attending continuing education programs (Bd., Dec. '72).

18. Supported the principle that regional seminars be established in the district branches to teach teachers how best to conduct continuing education programs, if funds are available from the profits of the second self-assessment program (PKSAP-II) (Bd., Dec. '72).

19. Recommended that the Association assume direct and stronger leadership in fostering continuing education (Bd., Feb. '73).

20. Approved in principle establishing a Second Joint Commission on Mental Illness and Health, with the intent that this be a joint venture with other organizations, and approved the establishment of an ad hoc committee—to be assigned to the Council on Mental Health—for preliminary planning of a Second Joint Commission (Bd., Feb. '73).

21. Requested the Reference Committee to commission a study of the current method of reviewing task force reports, with a view to the possibility of establishing a joint publication review committee of the Assembly and the appropriate council and/or Board of Trustees subcommittee (Bd., Feb. '73).

22. Suggested to the Reference Committee the appointment

of a task force to define the terms "mental illness" and "psychiatry" (Bd., Feb. '73).

23. Sent to the Reference Committee a request that the *Diagnostic and Statistical Manual of Mental Disorders (DSM-II)* be revised, that this task be made the responsibility of the Council on Research and Development—with a time limit of two years—and that such a revision be related to the problem-oriented medical record (Bd., Feb. '73).

24. Recommended that whatever terminology is used in defining "functional disability" be subject to classification by diagnostic category and quantitative evaluation in percentages of the degree of functional disability associated with each category (Bd., Feb. '73).

25. Recommended that the Falk Fellowship Program be continued contingent upon funding from the Maurice Falk Medical Fund or other outside resources, and that this year the possibility be explored of an increased subsidy to make it possible for one-year current Falk Fellows (who are eligible and have one more year of residency training) to have a second year of work with the committees—as a trial to see if it adds materially to the value of the program (Ex.C., Feb. '73).

26. Asked the President to appoint an Ad Hoc Committee on Professional Standards Review Organizations—to be assigned to the Council on Mental Health Services—for joint action with a similar committee of the Assembly (Ex.C., Feb. '73).

27. Respectfully rejected Dr. Barton's resignation at this time and asked him to remain on as Medical Director until at least June 1, 1974 (Bd., Dec. '72).

28. Accepted Dr. Barton's recommendations as to procedures for selecting his successor and asked the President to appoint as soon as possible a search committee to survey the job potentials and definitions and promptly consider possible candidates (Bd., Feb. '73).

29. Authorized the Search Committee on Functions and Qualifications of the Medical Director to inquire of each candidate his willingness to have his name submitted. The Executive Committee also approved the Search Committee's wish to accelerate the process of reporting in order that it may finalize its work of selecting appropriate candidates for the Board's consideration in time for an orderly transition in the exchange of Medical Directors (Ex.C., Apr. '73).

30. Accepted the amendment of APA's Retirement Plan Trust on Plan A in order to meet requirements of Revenue Ruling 71-461, and authorized that the revised Retirement Plan Trust be submitted to the Internal Revenue Service for approval (Ex.C., Apr. '73).

ROBERT W. GIBSON, M.D.

Report of the Treasurer

GENERAL: Once again the auditors are still at work on their annual review of the Association's fiscal accounts. As a consequence, the report given here, at the time of the annual meeting, is based on unofficial figures derived from the Association's own fiscal accounting records. Although there will be minor changes within accounts, the report does give an analysis of the fiscal status of APA.

INCOME AND EXPENDITURES: The actual expenditures and income for the fiscal year ending March 31, 1973, were $3,125,501.73 for expenditures and $3,674,840.42 for income. Expenditures and income were each budgeted at $3,364,558.00.

BOARD OF TRUSTEES: The Board of Trustees' account operated at a deficit because the Board held an extra meeting this year that had not been projected. I have asked the Budget Committee to review the contributions of APA to national councils and national organizations and to develop a policy for next year's involvement. The Association, in exercising its leadership role, has maintained extensive liaison with many organizations. This expense is paid from the Contingency Fund.

HOUSEKEEPING COMMITTEES: The constitutional committees lived within their budgets largely because the added expense of the Association's ballot counting was managed by an outside agency and was not billed to the Committee of Tellers during the fiscal year that ended March 31, 1973. We must wait and see whether the $10,000 additional cost for this new arrangement meets the organization's needs. Expenditures under this account were increased by the Ethics Committee's holding additional meetings as it struggled to develop ethical guidelines.

COUNCILS: The councils met as often as was required. There were more task forces in operation than ever before in the history of APA. However, all councils lived within their budgets and turned back to the organization approximately $30,500. It is evident that the importance of the councils, committees, and task forces is recognized and that it is possible for essential business of the Association to be transacted within the amounts appropriated.

INTERNAL ORGANIZATION: Pressures on the Medical Director's Office for additional services continue to be received. Although some departments and divisions exceeded their budgets slightly, savings in others more than offset these overages. The Medical Director's Office and the Division of Public Affairs lived within their budgets, as did the Joint Information Service (JIS), the Membership Division, the Administrative Services Division, the Accounting and Fiscal Division, the Division of Manpower Research and Development, the Meeting Management Department, the Assembly of District Branches, and the Minority Group Program Development Department.

PUBLICATIONS: Although *Psychiatric News* exceeded its estimated expenses by over $43,000, it also exceeded the estimated income by over $90,000. It continues to be the favored advertising medium and to operate soundly in the black.

The American Journal of Psychiatry spent approximately $109,000 less than was estimated to be the cost of producing the journal in its new format. However, its earnings were approximately $35,000 less than anticipated. This was due to a decrease in the number of advertising pages carried.

Hospital & Community Psychiatry has greatly improved its format, content, and financial position during the past year. On the expense side it operated with a surplus of over $37,000; its income was more than $24,000 less than anticipated. This is the second year this journal has continued to improve fiscally.

Some APA publications that did exceptionally well during the year were: *Desk Appointment Book; A Psychiatric Glossary; Diagnostic and Statistical Manual of Mental Disorders (DSM-II);* and the JIS publications *Children and Mental Health Centers: Programs, Problems, Prospects* and *The Treatment of Drug Abuse: Programs, Problems, Prospects.* Also doing well are *Health Insurance and Psychiatric Care: Utilization and Cost* and *Prospects and Proposals: Lifetime Learning for Psychiatrists.* The success of these publications helped balance the loss from the publication of many other important documents such as task force reports and data not available elsewhere.

EMPLOYEE BENEFITS: Personnel policies and salary adjustments necessary to keep APA abreast of federal wage scales required adjustments of staff salaries for the cost of living and for the expansion of the pension plan. However, the cost estimates as budgeted were not exceeded.

ANNUAL MEETING: The annual meeting in Dallas, Tex., showed a deficit in income over that budgeted of over $16,500. It also showed an expenditure of nearly $9,000 less than budgeted. It is anticipated that the deficit for the annual meeting in Hawaii may exceed $50,000. Annual meetings are far from self-sufficient fiscally.

INVESTMENTS: Investments in short-term securities amounted to $492,914 at the end of the 1972 fiscal year. At the end of fiscal year 1973 the amount was $481,148, plus insured certificates of deposit of approximately $300,000.

Short-term investments in commercial paper amounted to $881,374 (with a face value of $900,000), giving an overall total of $1,365,522 for short-term investments.

In spite of an uncertain year in the market and declining interest rates, the market's recovery at the end of the year made it possible to show a fair return on our investments.

The Treasurer, Medical Director, and Comptroller have worked closely with APA's investment counselor, Merrill Lynch, Pierce, Fenner, and Smith, to maintain a positive long-term investment outlook in a fluctuating market.

As of March 31, 1972, the investment portfolio showed a market value of $1,113,874. One year later, as of March 31, 1973, the amount was $1,051,703.[1]

This is an edited version of the report presented by the Treasurer at the annual business meeting in Honolulu, Hawaii, May 8, 1973.

[1] The decrease in the market value is due to the sale of stock, and funds were not reinvested.

The institution of an improved billing and reporting procedure last year made it possible for the organization to obtain a reading on late and unpaid dues. As of March 31, 1973, 90.5 percent of the members had paid their dues. The remaining 9.5 percent may be expected to pay within the next few months. Only a very small percentage of the members will fail to do so. The amount paid exceeded budget estimates by $147,000.

As the inflationary spiral continues, as the cost of everything we do expands, and as the activities and interests of the Association continue to require more support, the cost of operating the Association will naturally increase. Coupled with this will be a greater problem in securing grants, which have in the past represented a significant portion of the total budget of the Association.

Although we have been able to develop a surplus of $560,000 during this fiscal year by carefully controlling expenditures and collecting more dues than anticipated, next year's budget may require a raise in dues in a pattern consistent with the inflationary spiral. The Budget Committee will grapple with this problem when it meets in the fall.

AMERICAN PSYCHIATRIC MUSEUM ASSOCIATION, INC.: During the 1973 fiscal year, $135,000 was advanced by the Board of Trustees to the American Psychiatric Museum Association, Inc. Official notes were received from the Museum's Board of Directors to cover this amount.

Friends of the Museum has been organized and has contributed approximately $3,000 for special purposes of the Museum. No significant bequests, gifts, or grants have been forthcoming to operate this activity. Loans from APA continue to be its principal source of revenue.

This is my last report as your Treasurer. I am grateful to the members, the Assembly of District Branches, and the Board of Trustees for their support and understanding during these many years I have served you as chairman of the Budget Committee and as Treasurer. I leave my office with a sense of pride in the achievements of an increase in the fiscal resources of the Association and a sound fiscal position.

HAYDEN H. DONAHUE, M.D.

TABLE 1
General Fund Operations, Fiscal Year Ending March 31, 1973

Division	Expenses			Income		
	Actual	Budget	Variance	Actual	Budget	Variance
Board of Trustees	$ 80,282.89	$ 70,300	$ (9,982.89)			
Board of Trustees Contingency Fund	60,345.53	60,000	(345.53)			
Constitutional committees	14,300.02	17,400	3,099.98			
Coordinating councils						
Medical Education and Career Development	30,169.77	31,500	1,330.23	$ 600.00	$ 2,300	$ (1,700.00)
Mental Health Services	13,866.50	16,000	2,133.50			
Research and Development	13,647.50	15,000	1,352.50			
National Affairs	16,663.04	23,750	7,086.96			
Professions and Associations	19,586.12	19,200	(386.12)			
Internal Organization	22,628.99	32,500	9,871.01			
Emerging Issues	4,494.13	8,500	4,005.87			
International Affairs	6,376.56	9,000	2,623.44			
Total	127,432.61	155,450	28,789.63	600.00	2,300	(1,700.00)
American Journal of Psychiatry	555,220.98	664,597	109,376.02	583,624.46	619,000	(35,375.54)
Psychiatric News	498,861.27	455,397	(43,464.27)	587,665.27	488,400	90,265.27
Hospital and Community Psychiatry Service	347,579.87	385,329	37,749.13	250,603.50	274,000	(23,396.50)
Hospital and Community Psychiatry Institute	48,887.30	43,400	(5,487.30)	49,203.59	55,000	(5,796.41)
Medical Director's Office	164,668.45	165,052	383.55			
Public Affairs Office	78,480.03	80,353	1,872.97			
Joint Information Service	67,137.45	69,423	2,285.55	64,998.90	43,992	21,006.90
Membership Division	64,149.08	65,062	912.92	1,218,579.35	1,070,600	147,979.35
Administrative Services	74,807.52	75,622	814.48			
Accounting and Fiscal	69,249.37	71,144	1,894.63			
Professional Services	33,916.69	32,550	(1,366.69)	170.00	1,000	(830.00)
Publications Services	220,066.05	176,057	(44,009.05)	190,308.24	157,147	33,161.24
Manpower and Statistics	99,345.46	102,512	3,166.54	25,093.41	15,000	10,093.41
Meetings Management Office	53,158.01	58,678	5,519.99			
Annual meeting	134,060.33	142,960	8,899.67	108,670.09	125,200	(16,529.91)
Assembly of District Branches	53,247.89	60,311	7,063.11			
Minority Group Programs	26,375.19	43,954	17,578.81			
Operation and maintenance of central office	50,810.75	52,250	1,439.25			
Employee benefits and taxes	171,770.17	175,200	3,429.83			
Miscellaneous expenses/income	31,348.82	141,557	110,208.18	604,323.61	512,919	91,404.61
Totals	3,125,501.73	3,364,558	239,056.27	3,674,840.42	3,364,558	310,282.42

TABLE 2
Comparison of General Fund Assets at Year End, 1972 and 1973

Account	Year Ending March 31, 1973			Year Ending March 31, 1972		
Cash						
Checking account		$ 17,288			8,914	
Custodial account		198,870			22,773	
Certificates of deposit		300,000			305,386	
Petty cash		400			400	
Accounts receivable			$ 516,588			337,473
Deferred charges and prepaid expenses			168,391			186,260
Accrued interest receivable			49,350			60,991
Marketable securities			17,811			1,175
Long-term	($992,064)*	1,051,703		(1,025,986)*	1,113,874	
Short-term	(881,374)*	881,374	1,933,077	(492,914)*	492,914	1,606,788
Central office (at cost)		297,786			297,786	
Less—accrued depreciation and valuation reserve		297,784	2		297,784	2
Total assets			2,685,189			2,192,689
Deduct						
Marketable securities allocated to Special Purpose and Restricted Funds			258,315			174,411
Total general fund			2,426,874			2,018,278

*"Cost" or price at which purchased.

Report of the Medical Director

IN THIS MY TENTH REPORT I propose to sketch some of the ways in which your headquarters staff supports the work of the Association. The focus will be on the work done in the fiscal year just concluded and the problems that must be faced in the next few years. The staff joins you, the members, in the anticipation of a new era of progress under new officers and new APA staff leadership.

ADMINISTRATION

Management by objective is an elusive concept in an organization of 20,000 members with multiple goals and differing priorities. A group of members cluster around a shared goal to which they would give priority. Other groups of members may question whether the first group's objective is a legitimate one for the Association. Consensus may not be achievable on some issues. Your staff must hear many voices, receive many suggestions, and be responsive to many publics—members, patients, consumer advocates, concerned citizens, organizations, medical specialty associations, mental health professional and paramedical workers, and local and national governments.

The Association office always responds, sometimes with only an acknowledgment, often with substantive action, occasionally with referral for study, and, when indicated, attempts to negotiate differences.

Your staff answers its thousands of inquiries promptly. Our special talent is to relate the inquiry to the source of information. We struggle to provide material needed as background to decision making by the Assembly and its Executive Committee and by the Board of Trustees and its Executive Committee. Support is also given to councils, committees, task forces, and boards. We have worked hard to earn your confident expectation that the APA headquarters staff will respond appropriately and with integrity.

Extra sessions of the Board of Trustees and the Reference Committee were held this year. Attention was directed to improving organizational efficiency and accelerating the rate of response. An extra meeting of the Executive Committee was scheduled to hear annual reports of APA components. This enabled the Board of Trustees, at its meeting in Hawaii, to devote most of its time to substantive discussion of policy.

FISCAL

Ten years ago the Association operated from three widely separated offices. The editorial office of *The American Journal of Psychiatry* was in Toronto, the Association's business office was in New York, and the headquarters was in Washington. It had limited resources. Today your Association has but one office and by living within its budget has accumulated reserves.

Fiscal control ensures accountability. The wise use of resources has made it possible to set aside enough money in long-term investments to permit the purchase of additional property to expand operations at some future date. Money collected from dues and other income has been put to work in short-term investments timed to be available as bills become due. My goal has been achieved—to have enough reserve to meet obligations and cover six months of operating expense.

The Association has greatly expanded its publication operations. Its periodicals, *The American Journal of Psychiatry* and *Hospital & Community Psychiatry*, appear monthly; *Psychiatric News* is now published twice each month. These publications operate in the black. Task force reports, books, and pamphlets represent an extension of APA's publication efforts. A sizable staff is required to edit and publish these materials. Sound fiscal policies and fair pricing to recover costs result in a nonprofit, no-loss operation. Your Association's fiscal status is sound.

If your demands for service increase, and if the inflationary spiral goes unchecked, greater costs will require new income from dues. The auditors have already suggested further centralization of fiscal systems, computerization of accounting records, and a deputy director for business administration. These suggestions are under study.

RESEARCH AND PROJECTS

The Joint Information Service (APA-National Association for Mental Health) has just published *Mental Health on the Campus*, a field study. Under way are studies of services to children under the age of six and a study of the patients seen in private practice and the duration of their treatment.

An extensive project requiring much staff assistance is being supported by the Smith Kline & French (SKF) Presidential Fund of Dr. Perry Talkington. A monograph on *Gaps in Delivery of Mental Health Services* will be published in the winter.

The SKF Presidential Fund of Dr. Robert Garber supported a study of alternate strategies for funding psychiatric residency training.

The SKF Presidential Fund of Dr. Ewald Busse supported a project whose product is *Mental Illness in Later Life*, a book to be published by APA in May 1973.

Dr. Zigmond Lebensohn and the Medical Director, with Mr. Robert L. Robinson as science writer, have prepared a report on *The Present and Future Importance of Patterns of Private Practice in the Delivery of Mental Health Services*, based on a task force study some two years ago.

The Manpower Research and Development Division has completed its study of the 1970–1971 APA census of psychiatrists, a study of academic resources for training in psychiatry, and a survey of all residents in psychiatry. A new *Descriptive Directory of Psychiatric Training Programs in the United States, 1972–73* was published this month and is now available.

A study of foreign medical graduates in public institutions is nearing completion, and it is possible that a study of Diplomates of the American Board of Psychiatry and Neurology, Inc., may be undertaken shortly.

The computer system was redesigned this year to make access to information easier and retrieval less costly.

Dr. Lee Gurel is the new director of the Manpower Re-

This is an edited version of the report presented by the Medical Director at the annual business meeting in Honolulu, Hawaii, May 8, 1973.

search and Development Division.

A new Minority Group Program Development Department was established at APA headquarters in the fall of 1972, with Dr. Elvin Mackey as its director.

PUBLIC AFFAIRS

The image of psychiatry has eroded as a consequence of blasts from within and without our membership. Mr. Robert L. Robinson (who had his 25th anniversary as Director of Public Affairs for APA this year) presented an eloquent paper on the criticisms of psychiatry at the meeting of the American College of Psychiatrists in January 1973. It will be published in the proceedings of that meeting. It will also form the basis for further study at the Past Presidents' policy seminar during this annual meeting. Psychiatrists, unlike their nonpsychiatrist medical colleagues, have a propensity for self-flagellation in public. If we are to improve our public image, we need to study our own behavior.

The Public Affairs Division produces the program book for the annual meeting and the book of summaries of the presentations made. It produces the popular and useful *Desk Appointment Book* and edits APA reports and books. This year it published a summary pamphlet of all APA position statements.

Psychiatric News, edited by Mr. Robinson, has grown to be the principal medium of information on newsworthy events of national interest to the field of psychiatry.

Very prominent in the public eye is the Government Relations Section. Staff members assemble information for statements describing APA's stand on issues that concern the field of psychiatry to be presented to committees and individual members of Congress. This section also works with coalitions and liaison groups to share information and plan for coordinated action. In March of this year a second Government Operations Institute was held, attended by area and district branch legislative representatives. A network of legislative representatives has been formed to mobilize public support for the national mental health programs and, as the scene shifts to revenue sharing, for support of the programs at the state and local levels.

MAKE A JOYFUL NOISE

Your voice is but a whisper amid the babble of the multitude when you speak alone. If your brother members in the Association add their voices to yours, you can be heard. If all of medicine speaks with one voice, and if the mental health professions speak together, if patients, consumers, and the vast public join in, it will indeed make a joyful noise. That great voice will be heard and the monuments in Washington will tremble. We, the staff, cannot protect you from the "blessings" of the future. Speak up! It is your collective voice that will help shape the world about you.

WALTER E. BARTON, M.D.

Report of the Speaker

EACH ADMINISTRATION of the Assembly has had its own priorities. This administration has been no exception. For the past year emphasis has been placed on the development of peer review standards and on mechanisms for evaluating psychiatric services, continuing education, and the involvement of younger members in the Association. These are all relatively new concerns for the Assembly and the Association, and they have developed their importance not, unfortunately, on their own merits, but as a response to external pressures.

This type of reactivity—in contrast to initiative—has been the perennial custom of organized medicine, possibly to its detriment. The admonition "If you don't do it for yourselves, somebody else will do it for you" has stimulated the profession ever since federal authorities and the consumer began to take an active interest in the health field. As a result, the Assembly, in concert with other elements of the Association, has become more politicized and, by extension, defensive than heretofore. I cannot say whether this fact is good or bad, but I can report to you what the Assembly has done in response to the implied demands of our sociopolitical ambiance.

The Assembly has approved publication of the task force report on peer review and has insisted that each district branch have a functioning committee and a written plan for psychiatric peer review by April 1 of this year. At the present time, 18 district branches have submitted such reports. We hope that our membership will be prepared to help implement the activities proposed in the Bennett Amendment.

Through the Speaker-Elect of the Assembly, who served as chairman of the Committee on Constitution and By-Laws, an amendment to the Constitution has been proposed and approved by the Board requiring each member to submit annually proof of continuing education as a condition of membership. Each district branch has a committee on continuing education preparing programs that will be subject to approval by APA's Office of Continuing Education.

We have been less successful regarding the involvement of younger members in the Association. From over 5,000 residents in psychiatry, the Association has been able to attract fewer than 600 into participating membership in spite of an active recruiting campaign conducted by the Assembly, the central office, and the Division of Public Affairs, which has prepared an excellent recruiting pamphlet. A Committee of Residents, attached to the Council on Internal Affairs, has now been activated, with liaison with the Assembly. Perhaps this committee can provide insight into the unanswered question of why younger psychiatrists do not affiliate earlier.

All three of these priorities have had their basis in political pressures and reflect the increasing politicization of the Association, both from within and outside its ranks.

Externally, we have been beset by reduced federal support for a variety of mental health programs, the imminence of national health insurance (NHI) proposals that uniformly discriminate against consumers of mental health services, and a strong antipsychiatric bias based on mistrust of the profession, economic caution, and lack of appropriate information regarding psychiatrists and their spheres of operation. The requirement to justify the need for professional services, already mandated in the Professional Standards Review Organization (PSRO) legislation, will increase unless the doubt and mistrust of the authenticity and reliability of psychiatric services are alleviated.

When the Association has attempted to prolong federal support of manpower training, the following objection has been raised: "Why should taxpayers' dollars be spent to train psychiatrists who go into private practice and get rich?" If one points out that the median income of psychiatrists is less than $36,000 annually, legislators readily answer that this fact is due to the high employment of psychiatrists in state hospitals. This type of circular reasoning is difficult to counter. We are frequently met by such questions as: "What does a psychiatrist do?"; "Does psychiatry cure anybody?"; "Why is it so expensive?"

The Assembly has made attempts to meet these challenges by appointing a task force to develop a report on psychiatrists' areas of competence, defining their role and establishing their boundaries. This task force will attempt to delineate the professional capability of our members and to explicate the common denominator of professionalism in the face of marked fragmentation of modalities and so-called schools of psychiatry within the profession.

The district branches quite successfully mounted a strong mail and telephone campaign to restore federal training funds, only to have the allocated funds impounded by the Administration. In addition, legislative representatives of the district branches have attended two institutes on government relations for the purpose of forming a forceful network of legislative advocates for mental health concerns throughout the country. The response to pressures for social reform has resulted in a policy statement on homicide prevention via gun control, a statement concerning the rights of patients subject to involuntary hospitalization, and a Task Force on Sexual Stereotypy.

During the present meeting of the Assembly, a resolution for expanding the legislative influence of the Association through the establishment of a separate office of government relations was introduced. It is clear that the Assembly, if not the entire Association, has been impelled to put political concerns higher on its priority list than other issues.

From within the Association, the Assembly, no less than other elements of the organization, has been subject to criticism by fellow members—all the way from those who would destroy the present structure of APA and rebuild it on another model, through those who wish to convert the Association into a totally socially activist organization, to those—perhaps more clinically oriented—who declare that schizophrenia is not to be considered a disease process and that homosexuality is.

In the face of these internal stresses, the Assembly has remained an island of stability and continuity, able, by its very nature and at the risk of sometimes appearing conservative rather than deliberative, to maintain a course of evolutionary progress and responsibility in fulfilling its role as a legislative interface between the membership and the APA administration.

As the outgoing Speaker of the Assembly I feel privileged to speak about the course of future concerns for the Assembly. First, I feel that the Assembly now has a constitutional right to speak for the membership of the entire Association and has the

This is an edited version of the report presented by the Speaker of the Assembly of District Branches at the annual business meeting in Honolulu, Hawaii, May 8, 1973.

channels for discerning the tenor of the membership's attitudes. Second, if the Assembly is to assume a role of legislative advocacy for progress in mental health programs, it must assume a stance of responsibility. If we are to go before the legislatures and campaign for a portion of the taxpayers' dollars in return for better service to the population as a whole, we must be willing to assume our share of the load. If we wish to train more psychiatrists for the welfare of the nation at the expense of the nation, then our resources must reflect our rhetoric, our distributive mobility must match our motivation; and our declarations must derive from our deeds.

The Assembly has had a Task Force on Delivery of Mental Health Services for over three years. It must now turn its attention somewhat away from legislative concerns such as NHI, PSROs, and other legislative proposals and begin developing plans for easy accessibility to mental health services by all elements of our population, with assurance that consumers from all socioeconomic levels will receive an equally high quality of care. This will require cooperative planning with other mental health professionals for meeting the needs of an anxiety-ridden populace.

We have a Committee on Public Information that can easily be converted into a Committee on Public Education. Rights of patients must be matched by patient responsibility. Without appropriate education, patients cannot exercise their responsibilities or demand their rights. One cannot legitimately demand good health as a right; one can demand good medical care. In spite of the fact that psychiatrists allege they can determine what is good psychiatric care, they have been the last to assume advocacy for the consumer, leaving this important task to the courts. It is time for the Assembly and the district branches to consider performing this function.

The Assembly has been and is a well-tuned instrument of the membership. Sometimes the constituency has played it with dissonance, most often with harmony. Its capacity for stability and continuity as a representative of the total membership represents a marked asset to the Association. I trust that it will not be allowed to stand idle, like a well-polished Steinway standing decoratively in a living room, but unplayed. Instead I urge you, the instrumentalists, to play it well for the benefit of the membership and for the welfare of the applicants for our services.

JAMES C. JOHNSON, JR.

Report of the Speaker-Elect

THE AMERICAN PSYCHIATRIC ASSOCIATION is an organization of physicians specializing in psychiatry who have associated themselves in the pursuit of certain shared goals. The Association is founded on the implicit assumption that more can be accomplished by acting collectively than could be accomplished by individual action. The purposes of the Association, as set forth in its Constitution, are improvement in the care, treatment, and rehabilitation of the mentally ill, mentally retarded, and emotionally disturbed. The Constitution explains that the Association intends to accomplish this by research, education, standard-setting, and the dissemination of information to allied disciplines and the public. The vitality and viability of the Association is dependent on whether it brings about progress toward these goals—progress that could not have been accomplished by the members acting individually.

The goals are idealistic, and it is apparent that it is the intent of the members that their Association shall be an instrument for the collective expression of this idealism. The Association has been granted the highest form of tax-exempt status, which in actuality is the equivalent of a subsidy by public funds. Because of this the Association has a responsibility to the public as well as its members.

The organizational structure of the Association must therefore provide the means for an active pursuit of these goals and must at the same time provide an opportunity for active participation in the Association by the members.

If the Association is to be an effective instrument for the expression of the idealistic concerns of the members, vicarious participation is not adequate. The members must be able to identify with the Association and identify it as an extension of themselves.

For the individual members to identify with the Association and have a significant voice in its affairs, APA must have a democratic structure, with open elections and officers and a governing body that is accountable and responsive to the wishes of the members. Traditionally the Association has been regarded as having such a structure, but with growth in membership and geographical dispersion after World War II, the Association took on more of the characteristics of a large corporation than of a democratic society. The annual business meeting, which was supposed to be an example of town meeting democracy, became in fact a pro forma endorsement by APA members of the actions of the officers and governing body.

As a result, the distance between the members and governors of the Association gradually increased, and effective contact was lost. The officers and governing body were dedicated to the goals of the Association and acted effectively to capitalize on the increased interest in mental health that occurred after World War II. Unfortunately, however, the members were to a large extent unaware of these accomplishments or of the role of their Association in bringing about productive change, such as the establishment of NIMH and the Joint Commission on Mental Illness and Health, or APA's support for education in psychiatry and related disciplines.

This is an edited version of the report presented by the Speaker-Elect of the Assembly of District Branches at the annual business meeting in Honolulu, Hawaii, May 8, 1973.

The committees of the Association were the only means open to members for active participation, but even though the number of committees increased to a fantastic and unwieldy number, only a small fraction of the total membership was involved.

A number of developments can be attributed in part at least to this loss of contact with and alienation of individual members. Repeated major and minor palace revolutions occurred in which one establishment was partially or completely replaced by another. A major concern of the Airlie House Conference in the mid sixties was the internal organization of the Association. Some of the recommendations from the conference were clearly in the direction of representative democracy, and the presence of six area Trustees on the Board was a direct result of those recommendations. Recommendations were made for a change to a task-oriented committee structure and for elimination of the multitude of standing committees. The present system of the Reference Committee and councils was a direct result of those recommendations.

Perhaps the most significant example of reaction to the loss of contact and alienation of the members was the development of the Assembly and the district branch system. It was founded just 20 years ago and began an immediate, vigorous growth in both members and influence, a growth that has continued.

This vigorous growth occurred because the Assembly is representative democracy in action, providing an opportunity for the individual member to participate directly in his chapter and district branch and to influence the vote of his representative in the Assembly.

Initially the Assembly did not have any formal role in the Association and was largely ignored by its officers and governing body. It was widely regarded as impotent and was tolerated because of its usefulness in providing a podium for empty oratory as a safety valve to relieve the pressures and tensions that had developed in the membership.

The image and role of the Assembly have gradually changed during these 20 years. Initially, only a small fraction of APA members were members of district branches. Now district branch membership is a requirement for APA membership for all except a small percentage, who are members-at-large under a "grandfather clause."

The officers and governing body have become more and more dependent on the Assembly for contact with the membership. The Assembly serves a vital function in informing members about issues and actions and informing the Board and the officers about prevailing opinion and sentiment among the members.

The Assembly has a pyramidal structure. The delegates in each of the six geographical areas are organized into area councils headed by an area representative and deputy area representative. These 12 officers, together with the officers of the Assembly, make up the Executive Committee of the Assembly. The Executive Committee is authorized to act for the Assembly when it is not in session.

Significant increases in power and influence were granted to the Assembly in the 1968 and 1972 revisions of the Constitution and By-Laws.

The Speaker became an ex-officio member of the Board and its Executive Committee. The Speaker-Elect is now an ex-officio member of the Reference Committee.

Perhaps the most significant change was authorization for the Assembly to act for all of the membership at the annual meeting in receiving for approval or disapproval the reports of actions by the Board and the officers during the preceding year.

In addition, the Assembly was given authority to call for a referendum of the membership on any action of the Board or its Executive Committee that the Assembly regarded as being contrary to the best interests of the Association or the wishes of the membership.

Additional changes are under way that will become operative during this coming year. This year's budget includes funds for an additional area council meeting. This will make it possible for each area council to meet four times during the year and will provide the potential for much-needed improvement in the legislative function of the Assembly.

A very significant development was approval by the Board of the appointment of a representative from the Assembly Executive Committee to sit with each council.

Investigation, study, and planning by the councils and the Reference Committee are the basis for the policies, position statements, and programs expressing the goals of the Association.

This new relationship between the Assembly and the councils will bring together the two elements in the Association that are essential to its viability—effective participation by the membership and progress toward the goals of the Association.

The Assembly has now reached adulthood, but this new status carries with it great responsibility. Continuing study of, refining, and improving the functioning of the Assembly are needed if it is to adequately discharge its responsibility to the members, the Association, and the public.

WARREN S. WILLIAMS, M.D.

1973 Annual Report of the American Board of Psychiatry and Neurology, Inc.

OFFICERS AND MEMBERS OF THE BOARD

AT ITS ANNUAL MEETING in October 1972 the Board elected the following people as its officers: Dr. Samuel A. Trufant, President; Dr. Harvey J. Tompkins, Vice-President; and Dr. Robert L. Stubblefield, Secretary-Treasurer.

The following members were elected to succeed themselves: Dr. Milton Greenblatt and Dr. David B. Clark. Dr. Robert J. Joynt was elected to succeed Dr. Arnold P. Friedman, who completed his second term of four years on January 1, 1973. Dr. Marc H. Hollender was elected to succeed Dr. Lester H. Rudy, who resigned his Directorship May 31, 1972, to assume the position of Executive Secretary-Treasurer.

The 1973 Directors of the American Board of Psychiatry and Neurology, Inc., are as follows:

Appointed by the American Medical Association: Dr. Clark H. Millikan* (term expires December 1974), Dr. Robert L. Stubblefield* (term expires December 1975), Dr. Robert J. Joynt (term expires December 1976), and Dr. Shervert Frazier* (term expires December 1973).

Appointed by the American Neurological Association: Dr. Samuel A. Trufant* (term expires December 1974), Dr. William M. Landau* (term expires December 1975), Dr. David B. Clark* (term expires December 1976), and Dr. Thomas A. Farmer (term expires December 1973).

Appointed by the American Psychiatric Association: Dr. Chester M. Pierce (term expires December 1974), Dr. Harvey J. Tompkins* (term expires December 1975), Dr. Milton Greenblatt* (term expires December 1976), and Dr. Marc H. Hollender (term expires December 1973).

EXAMINATIONS

Effective July 1, 1973, the American Board of Psychiatry and Neurology, Inc., will accept an application for certificate immediately after the applicant completes his training program, provided the following requirements are met:

1. The applicant completes his training requirement no later than June 30 preceding the date of the Part I examination to which he is seeking admission.
2. The applicant files an application on the official form after July 1 of the year he completes training, and the application is received in the executive office no later than October 31 preceding the date of the Part I examination.

A candidate who elects this option will be required to take the next scheduled Part I following the date he is accepted for examination. Failure to do so will require reapplication and payment of the application fee. A candidate who passes Part I will be scheduled for Part II upon receiving credit for two years of experience.

This is an edited version of the report presented by the American Board of Psychiatry and Neurology, Inc., to the American Psychiatric Association, May 1973.

*These Directors are serving their second term of four years and are not eligible for reappointment.

TABLE 1
Number Declared Eligible and Notified for Part I Written Examination on April 23, 1973

Item	Psychiatry	Neurology	Total
Number declared eligible and notified	1,665	334	1,999
Number who declined or withdrew	588	30	618
Number remaining for written examination as of April 9, 1973	1,077	304	1,381

Part I

For the Part I examination given on April 17, 1972, 779 psychiatrists were tested; 500 (64.2 percent) passed and 279 (35.8 percent) failed. Of the 186 neurologists tested, 121 (65.1 percent) passed and 65 (34.9 percent) failed.

For the 1973 Part I examination, 1,077 psychiatrists and 304 neurologists have accepted assignment. See table 1 for the number of candidates declared eligible and notified for Part I in 1973, and table 2 for a comparison of these figures with other years.

Part II

There were 545 candidates present at the Part II examination given in St. Louis, Mo., on October 2–3, 1972. This was the largest examination the Board has administered. See tables 3 and 4 for the statistics for this examination and for the Part II given in Boston, Mass., on April 2–3, 1973.

Two large examinations are planned for the Part II 1973–1974 examining year. One examination will be given in Chicago on October 1–2, 1973, and a second one in Los Angeles on April 1–2, 1974. In the future the Board plans to maintain a schedule of two Part II examinations a year.

CHILD PSYCHIATRY

Members of the current Committee on Certification in Child Psychiatry are: Dr. H. Donald Dunton, Chairman; Dr. John F.

TABLE 2
Comparison of Last Five Years

Item	1969	1970	1971	1972	1973
Total eligible	1,460	1,682	1,751	1,552	1,999
Total who accepted examination	1,301	1,262	1,412	1,119	1,381
Total who actually appeared	1,006	1,065	1,068	965	—

TABLE 3
Analysis of Group Who Took Part II Examination in St. Louis, Mo., October 1972

Item	Psychiatry		Neurology		Child Neurology		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Number of candidates	450	82.5	76	14.0	19	3.5	545	100.0
Results								
Pass	297	66.0	55	72.4	12	63.1	364	66.8
Fail	64	14.2	9	11.8	0	—	73	13.4
Fail with two-year rule	29	6.5	5	6.6	3	15.8	37	6.8
Condition	60	13.3	7	9.2	4	21.1	71	13.0

TABLE 4
Analysis of Group Who Took Part II Examination in Boston, Mass., April 1973

Item	Psychiatry		Neurology		Child Neurology		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Number of candidates	261	79.1	63	19.1	6	1.8	330	100.0
Results								
Pass	161	61.7	46	73.0	4	66.6	211	63.9
Fail	26	10.0	3	4.8	—	—	29	8.8
Fail with two-year rule	41	15.7	6	9.5	1	16.7	48	14.6
Condition	33	12.6	8	12.7	1	16.7	42	12.7

McDermott, Vice-Chairman; Dr. Barbara Fish, Secretary-Treasurer; Dr. Stuart M. Finch; Dr. Jeanne Spurlock; Dr. Richard S. Ward; and Dr. Richard W. Olmsted, American Board of Pediatrics.

At its meeting in Madison, Wis., in March 1973, the Committee voted to increase application and examination fees. The following fee schedule became effective April 1, 1973: application fee, $150; oral examination, $200; oral reexamination-failure, $200; and oral reexamination-condition, $150.

In March 1973 the Committee conducted its annual examination. Of the 96 candidates examined, 55 were certified in child psychiatry.

The Committee received an award of $50,000 from the Grant Foundation to study certification in child psychiatry.

AMERICAN BOARD OF MEDICAL SPECIALTIES

The Board has a more forceful role in the American Board of Medical Specialties. Dr. Rudy has been appointed to the Committee on Certification and Recertification and the Committee for Long-Range Planning.

Proposed Amendments to the Constitution and By-Laws

The amended Constitution and By-Laws became effective in May 1973. The amendments that follow are identified as being proposed either by petition or by the Committee on Constitution and By-Laws. These proposals were received within the 60-day deadline before the annual meeting and were presented at the annual business session. They will appear on the ballot in March 1974.

Note: The following changes in type style indicate the following proposed changes in the Constitution and By-Laws: 1) underlining = proposed additions to the Constitution and By-Laws (e.g., "by resolution of the Assembly"); and 2) brackets = proposed deletions from the Constitution and By-Laws (e.g., "may originate [either] . . ."); Articles and sections of the Constitution and chapters and sections of the By-Laws that are not listed here have not been subject to any proposed changes.

Proposed Amendment to the Constitution

ARTICLE IX. AMENDMENTS

Section 1 (proposed by petition)

Proposals to amend the Constitution may originate either (a) by a petition signed by [200] 50 or more voting members, (b) by resolution of the Board, or (c) by resolution of the Assembly. A statement from those initiating the amendment setting forth the reasons for the action and a statement from the Board shall accompany the ballot.

Proposed Amendments to the By-Laws

CHAPTER ONE. MEMBERS

Section 3 (proposed by committee)

To maintain membership in good standing all members are required to participate in continuing education according to the standards of the American Psychiatric Association.

Sections [3] through [11] renumbered 4 through 12.

Section 6 (proposed by petition)

Fellows shall have been General Members for at least five years and shall have made a significant contribution to the field of psychiatry. At its discretion the Board, upon recommendation of the Membership Committee, may waive the requirement for five years as a General Member. The criteria and procedures for selection and nomination of General Members for Fellowship shall be established by the Board and the Membership Committee and shall apply uniformly for all District Branches.

CHAPTER FOUR. OFFICERS

Section 7 (proposed by committee)

[The Officers of the Association shall hold office for one year.] The President and Vice-Presidents are ineligible for re-election to the same office. The President shall hold office for one year. The Vice-Presidents shall be elected in alternate years, and each shall hold office for two years. The Secretary and Treasurer shall be elected in alternate years, and each shall hold office for two years.

Section 8 (c) (proposed by petition)

If any other office becomes vacant, the Board shall select [a Fellow] any voting member of the Association to fill that office for the remainder of the term.

CHAPTER SIX. COUNCILS, COMMITTEES, BOARDS, AND OTHER ORGANIZATIONAL ENTITIES

Section 5 (proposed by committee)

The Nominating Committee shall be appointed by the President within the first 60 days of [each] his term of office and shall be comprised of a representative from each geographical area of the Assembly plus a chairman. Each area council shall propose at least three candidates, and the President shall appoint the members from among those candidates. He may choose any voting member as chairman of the committee. The Committee shall nominate at least two candidates for each office and report its nominations [no later than October 31 of each year.] to the Board by October 1 for immediate dissemination to the members.

CHAPTER EIGHT. PRIVILEGES AND RESPONSIBILITIES

Section 3 (proposed by petition)

[Only Fellows and Life Fellows shall] Any voting member may hold elected office, serve on councils, or serve as chairmen of committees, boards, and commissions.

Section 5 (proposed by petition)

The voting membership may initiate referenda or change an action of the Board by the following procedure: A petition signed by at least [200] 50 voting members shall be submitted to the Secretary no later than January 1 to be voted on in the mail ballot for that year. A statement from the petitioners setting forth the reasons for the reasons for the action and a statement from the Board shall accompany the ballot. A simple majority of 40 percent of the eligible voting members shall be required for approval.

Section 6 (proposed by petition)

Every Fellow, Life Fellow, General Member, Life Member, Associate Member, and Member-in-Training shall pay both dues and assessments as determined by the Board and the District Branches. All other categories of membership shall be exempt from paying dues to both the Association and its District Branches.

CHAPTER NINE. VOTING

Section 1 (proposed by petition)

Any [Fellow or Life Fellow] voting member nominated for office by a petition signed by [200] 50 or more members eligible to vote shall have his name included on the official ballot for the next general election, provided that such petition has been filed with the Secretary before January 1 of the year he would be elected.

CHAPTER ELEVEN. ANNUAL BUSINESS MEETING

Section 1 (proposed by petition)

At a previously announced time during the Annual Meeting, the President of the Association shall convene a business meeting composed of two consecutive sessions: (1) a meeting of the Assembly to act for the membership in receiving a report of the actions of the Board and the reports of the Speaker of the Assembly, the Medical Director, the Treasurer, and the chairmen of the councils and the constitutional committees; and (2) an annual forum for all voting members. Only voting members of the Association may attend this business meeting.

Section 2 (proposed by petition)

The Assembly may vote [to approve or disapprove by majority vote the reported actions but may not reverse an action of the Board except through the process for a referendum as described in Section 6, Chapter Seven of these By-Laws. Only voting members of the Association may attend this business meeting.] by simple majority on any matters before the business meeting except to reverse an action of the Board, which will require a two-thirds majority vote of the Assembly.

CHAPTER TWELVE. ANNUAL FORUM

Section 1 (proposed by petition)

[At a previously announced time following the business meeting the President shall convene an open forum for all members to consider the present and future course of the Association.] After the conclusion of the first session of the business meeting, at a reasonable point within the time allotted for the business meeting as a whole, the President shall convene the annual forum session of the business meeting for all the voting members.

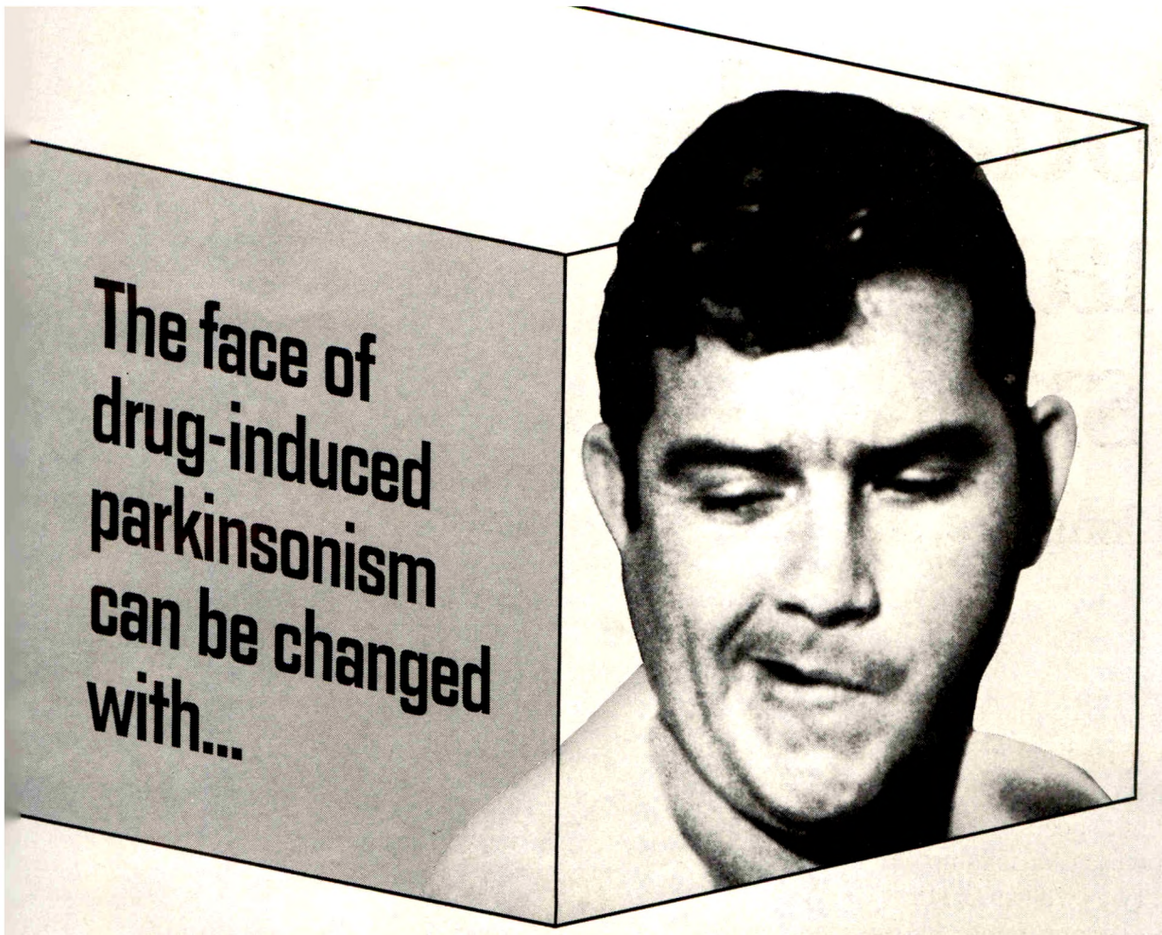
Section 2 (proposed by petition)

[Proposals about the affairs of the Association, including resolutions for referenda, may be introduced and if approved by a majority of the voting members present circulated in the next mail ballot of the Association. A two-thirds majority of the voting members may call for an extraordinary vote, and this shall require a mail ballot to be circulated and reported prior to the fall meeting of the Assembly.] Proposals about the affairs of the Association, and any old or new business, may be introduced and voted on by a two-thirds majority of the voting members present except to reverse an action of the Board or Assembly. To reverse an action of the Board or Assembly, a two-thirds majority of the voting members may call for an extraordinary vote, and this shall require a mail ballot to be circulated and reported prior to the fall meeting of the Assembly. In matters other than a Board or Assembly action, a simple majority of voting members present may initiate the referendum process as described in Section 6, Chapter Seven of these By-Laws.

Section 3 (proposed by petition)

After a referendum is approved by a two-thirds majority of the voting members present, the Board or Executive Committee shall review it to determine whether any conflict with the Constitution and By-Laws or with the legal status or established policy of the Association exists and shall [resolve] formulate an opinion on any such conflicts before it is circulated to the members. The circulated referendum shall carry with it both the opinion of the Board and the opinion of those initiating the referendum.

[Should the Board decide not to circulate any such referenda, a report of the decision and the reasons for it shall be published as expeditiously as possible in a publication of the Association.]



AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally; **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

traindications: Known hypersensitivity; acute recovery phase following myocardial rction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe vulsions, and deaths have occurred in patients receiving tricyclic antidepressant and OI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, inimum of 14 days should be allowed to elapse after the latter is discontinued. Protyline HCl should then be initiated cautiously with gradual increase in dosage until imum response is achieved.

nings: May block the antihypertensive effect of guanethidine or similarly acting comnds. May impair mental and/or physical abilities required for the performance of hazard- tasks, such as operating machinery or driving a motor vehicle. Should be used with tion in patients with a history of seizures and, because of its autonomic activity, in ents with a tendency to urinary retention or increased intraocular tension.

hycardia and postural hypotension may occur more frequently than with other antiressant drugs. Should be used with caution in elderly patients and patients with cardiocular disorders; such patients should be observed closely because of the tendency of drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the contion time. Myocardial infarction and stroke have occurred with drugs of this class. rare occasions, hyperthyroid patients or those receiving thyroid medication develop arrhythmias when this drug is given.

ge in Children: Not recommended for use in children because safety and effectiveness ne pediatric age group have not been established.

ge in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, in pregnant women, nursing mothers, or women who may become pregnant requires possible benefits be weighed against possible hazards to mother and child.

cautions: When protriptyline HCl is used to treat the depressive component of schizoenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, ressed patients may experience a shift toward the manic phase; paranoid delusions, n or without associated hostility, may be exaggerated. In any of these circumstances, it be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug currently. Symptoms, such as anxiety or agitation, may be aggravated in overactive gitated patients.

en given with anticholinergic agents or sympathomimetic drugs, including epinephrine nbined with local anesthetics, close supervision and careful adjustment of dosages are uired. May enhance response to alcohol and effects of barbiturates and other CNS ressants. Possibility of suicide in depressed patients remains during treatment and il significant remission occurs; this type of patient should not have easy access to e quantities of the drug. Concurrent administration with electroshock therapy may rease hazards of therapy; such treatment should be limited to patients for whom it is ential. Discontinue drug several days before elective surgery, if possible. Both elevation l lowering of blood sugar levels have been reported.

verse Reactions: *Note:* Included in this listing are a few adverse reactions which have been reported with this specific drug. However, the pharmacologic similarities among tricyclic antidepressant drugs require that each of the reactions be considered when triptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation l anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

diovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, hythmias, heart block, stroke.

chiatric: confusional states (especially in the elderly) with hallucinations, disorienta- n, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightres; hypomania; exacerbation of psychosis.

rological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, mors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG terns, tinnitus.

ticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturnce of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed turition, dilatation of the urinary tract.

ergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exsure to sunlight), edema (general, or of face and tongue), drug fever.

matologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; ombocytopenia.

strointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, matitis, abdominal cramps, black tongue.

docrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; reased or decreased libido, impotence; testicular swelling; elevation or depression of od sugar levels.

er: jaundice (simulating obstructive); altered liver function; weight gain or loss; spiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and gue; headache; parotid swelling; alopecia.

hdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after longed therapy may produce nausea, headache, and malaise.

erdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been orted to reverse the symptoms of amitriptyline poisoning in humans. Animal studies e shown that physostigmine also reverses certain toxic effects of protriptyline, but to sser extent.

w Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit kages of 100 and bottles of 100 and 1000.

more detailed information, consult your MSD representative or see full prescribing information.
ck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 26 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

Mental Illness in Later Life

by Ewald W. Busse, M.D.
Eric Pfeiffer, M.D.

A comprehensive, practical guide for the practicing physician about the emotional problems of the aged patient. Included are pragmatic suggestions for interviewing, diagnosis, treatment, and supportive care, with consideration of social, cultural, and psychological factors. A special *Question-and-Answer* section is a valuable supplement.

"The 12 well written chapters of this book, all by knowledgeable investigators in the field of geriatric mental illness, offer both an overall review of the current status of the field and more detailed information on such specialized topics as the demography of aging, the epidemiology of geriatric mental disorder, diagnostic procedures of the evaluation of brain impairment, social and psychological aspects of mental illness in the aged, insurance coverage for mental illness in later life, organic and functional geriatric mental disorders, physical changes with aging and their relationship to mental functioning, and institutional and ambulatory treatment of the aged mentally ill. The content and approach make the volume appropriate and useful reading both for psychiatrists, who have paid too little attention to the psychiatric problems of the aged, and for social workers, psychologists, nurses, and other personnel who deal with the elderly mentally ill. Pragmatic suggestions are made for interviewing, diagnosis, treatment, and supportive care, and there is adequate emphasis on social, psychologic, and cultural factors. The Question and Answer *section of the book is an especially valuable supplement, especially to readers whose interest is primarily pragmatic."*

ALEXANDER SIMON, M.D.
Professor and Chairman
Department of Psychiatry,
University of California, School of Medicine, San Francisco

308 pages — $7.00 for paperback/$9.00 for case-bound

Please send me _____ copy(ies) of **Mental Illness in Later Life.**

_____ Paperback @ $7.00 ea. (order # 188)

_____ Case-bound @ $9.00 ea. (order # 188-1)

(Please Print) ☐ Bill Me ☐ Check Enclosed

Name _____

Address _____

City _____ State _____ Zip _____

Send Coupon to: **American Psychiatric Association**
Publications Sales
1700 Eighteenth St., N.W.
Washington, D.C. 20009

1073AJP

We've got a new name



(potassium gluconate-potassium chloride)

(but that's all).

KALYUM™ Liquid (potassium gluconate-potassium chloride), that's our old name. The name you knew us by.

We liked it. After all it's the Latin pronunciation for "potassium." And potassium supplementation is what we're all about.

So why change our name to KOLYUM™ Liquid (potassium gluconate-potassium chloride)?

It just happens that our old name could possibly be mistaken for the name of a large product in another therapeutic category. So we decided to eliminate any chance of confusion by changing *our* name.

But our name is all we changed. Kolyum (new name) is still the same good-tasting cherry flavored potassium supplement you trusted under the name of Kalyum.

So from now on—whenever you want effective potassium supplementation *without sodium and calories*, remember our new name: Kolyum Liquid.

Kolyum Liquid.

Potassium supplementation gets a neat new name.

PRESCRIBING INFORMATION
DESCRIPTION—Each 15 ml tablespoon provides 20 mEq of potassium ion and 3.34 mEq of chloride ion in a sugar free, cherry flavored vehicle. INDICATION—Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication. CONTRAINDICATIONS—Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. PRECAUTIONS—Potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease. Extreme caution should be used in patients receiving aldosterone antagonists or potassium sparing diuretics. In both cases potassium intoxication might occur. ADVERSE REACTIONS—Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment and tall peaked T waves. DOSAGE—The usual adult dosage is one tablespoonful (15 ml) in one fluid ounce or more of water twice daily. This supplies 40 mEq of potassium ion which is the approximate minimal adult daily requirement, as well as 6.68 mEq of chloride ion. Deviations from this recommendation may be indicated, since no average total daily dose can be defined but must be governed by close observation for clinical effects. OVERDOSAGE—Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours. SUPPLIED: Pints and gallons. Dispense in amber glass containers.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623





When the symptoms add up to depression

ADAPIN®
(Doxepin HCl)

opens the patient to your counsel

Biphasic action helps you "get to" the depressed patient quickly.

Depressed patients are often difficult to reach. Some are lethargic; withdrawn. And in others, agitation masks the underlying depression.

Adapin (doxepin HCl) works on either—or both—phases: depression/agitation-depression. That's how Adapin quickly opens the patient to your counsel. Lets you work with him as the drug works to lift his depressive symptoms (usually in two to three weeks).

Dosage flexibility allows you to choose therapeutic approach.

In situations where drowsiness is clinically undesirable, you can start the patient on 10 mg. Adapin t.i.d. for four days (without reduced therapeutic effect) titrating the dosage upward after that as indicated. In patients where you deem drowsiness to be a desirable effect, you can initiate therapy with 25 mg. or more t.i.d. as the clinical situation dictates.

Further, with Adapin, you can titrate dosage upward in 10 mg. increments, allowing you greater therapeutic flexibility.

Single entity; low possibility of "cross reactions."

Adapin is single entity therapy. And there have been few reported instances of drug "cross reactions." In fact, one investigator[1] reported no adverse interactions between doxepin HCl [Adapin] and alcohol, hypnotics, neuroleptics, antihypertensive drugs, oral hypoglycemic agents, or anticonvulsants.

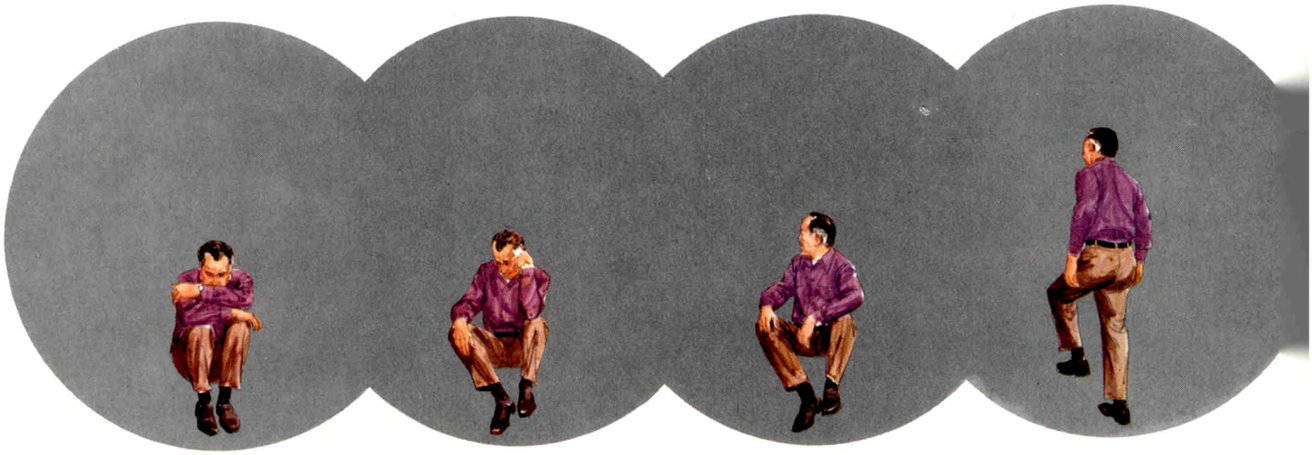
No addictive potential. No reported withdrawal symptoms.

Well tolerated by patients (even the elderly) with concomitant organic disease.

Low starting dosage; fine dosage titration.

1. Ayd, Frank J. Jr.: Long Term Administration of Doxepin. Dis Nerv Syst 32:617-22, Sept., 1971

Please see following page for prescribing information.



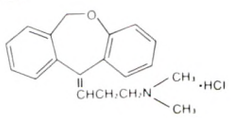
When the symptoms add up to depressio

ADAPIN®

(Doxepin HCl)

opens the patient to your counsel

COMPOSITION: Each Adapin capsule contains 10 mg., 25 mg., or 50 mg. of doxepin as the hydrochloride.



INDICATIONS: Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

CONTRAINDICATIONS: Adapin is contraindicated in patients with glaucoma or a tendency toward urinary retention, and in patients with demonstrated hypersensitivity to Adapin.

WARNINGS:

1. MAO inhibitors should be discontinued at least two weeks prior to cautious initiation of therapy with Adapin.
2. Adapin has not been evaluated in pregnant patients and should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.
3. Usage of Adapin in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Patients should be warned of the possible occurrence of drowsiness and cautioned against driving a motor vehicle or operating hazardous machinery. The effects of alcoholic beverages may be increased. Since suicide is an inherent risk in depressed patients, they should be closely supervised. The possibility of activating or unmasking latent psychotic symptoms during therapy should be kept in mind. Significant blocking of the antihypertensive effect of guanethidine is exerted at dosages of 300 mg. per day or higher. Potentiation of norepinephrine response in animals has been noted, but this effect has not been observed in humans.

ADVERSE REACTIONS: Anticholinergic Effects—Dry mouth, blurred vision and constipation; CNS Effects—Drowsiness; Cardiovascular Effects—Tachycardia and hypotension. Infrequently: extrapyramidal symptoms, gastrointestinal reactions, secretory effects (increased sweating), weakness, dizziness, fatigue, weight gains, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE: 10 mg. to 25 mg. t.i.d. to start. An initial dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients. Usual optimu dosage is 75 to 150 mg. per day. In some patients with mild emotional symptomatolog including that which may accompany organi disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control. More severe anxiety and/or depression may requi 50 mg. t.i.d. to start, gradually increased to 300 mg. per day.

OVERDOSAGE: Symptoms include an incre of the reported adverse reactions, primarily excessive sedation and anticholinergic effect as blurred vision and dry mouth. Other effect may be pronounced tachycardia, hypotensio and extrapyramidal symptoms. Treatment is essentially symptomatic with supportive therapy in the case of hypotension and excessive sedation.

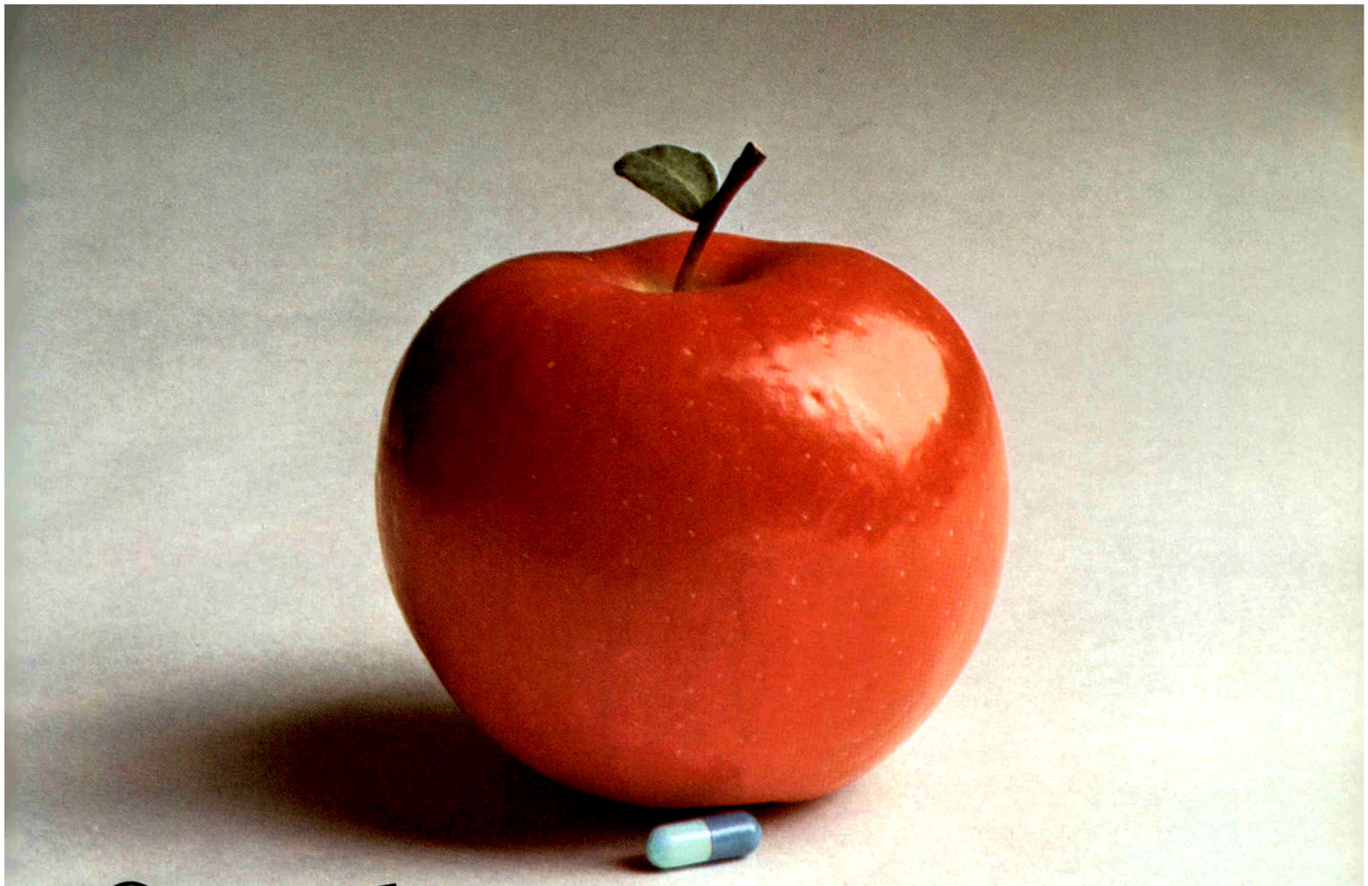
SUPPLIED: Each capsule contains doxepin, the hydrochloride, 10 mg. (NDC 18-356-71) and 25 mg. (NDC 18-357-71) capsules in bottles of 100 and 50 mg. (NDC 18-358-65) capsules in bottles of 50. Caution: Federal law prohibits dispensing without a prescriptic

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623

6749

Printed in U.S.A.



Once-a-day maintenance therapy. Introducing New Navane® 20 mg. (thiothixene) capsules

Once-a-day maintenance...

Once you've controlled acute psychosis or psychotic depression with a t.i.d. regimen, some patients can be maintained on one new Navane 20 mg. capsule a day. And for patients requiring higher dosages, two or three capsules, once a day, may be sufficient. This once-a-day regimen can reduce the risk of missed doses, with no loss of efficacy.

Once-a-day efficacy...

A recent double-blind, crossover study[1] compared Navane capsules, t.i.d., with an equivalent-dose once-a-day regimen. Both groups had statistically equivalent, significant clinical improvement over baseline at the end of the study period. And although the difference in extrapyramidal side effects was not statistically significant, the once-a-day group had a lower score.

Once-a-day economy...

For inpatient therapy, once-a-day Navane capsules can provide a saving of valuable nursing time. And for both institutions and outpatients, the 20-mg. capsule has another economy advantage: it's less costly than two 10-mg. or four 5-mg. capsules.

Navane 20-mg. It's a new dosage strength to maintain control of psychotic behavior. Effectively. Conveniently. And economically.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

1. Data on file, Roerig.

For prescribing information, including adverse reactions and contraindications, please see following page of this advertisement.

Navane® (thiothixene) (thiothixene hydrochloride)

Capsules: 1 mg., 2 mg., 5 mg., 10 mg., 20 mg.
Concentrate: 5 mg./cc.
Intramuscular: 2 mg./cc.

PRESCRIBING INFORMATION
Navane® (thiothixene)
Capsules 1 mg., 2 mg., 5 mg., 10 mg., 20 mg. (thiothixene hydrochloride).
Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

Actions. Navane is a psychotropic agent of the thioxanthene series. Navane possesses certain chemical and pharmacological similarities to the piperazine phenothiazines and differences from the aliphatic group of phenothiazines. Navane's mode of action has not been clearly established.

Indications. Navane is effective in the management of manifestations of psychotic disorders.

Contraindications. Navane is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but this possibility should be considered.

Warnings. *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane (thiothixene), there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration to rats (5 to 15 mg./kg./day), rabbits (3 to 50 mg./kg./day), and monkeys (1 to 3 mg./kg./day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions. An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane (thiothixene) may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane [thiothixene] for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis), have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Intramuscular Administration – As with all intramuscular preparations, Navane (thiothixene hydrochloride) Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus) and the midlateral thigh.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower- and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions. *Note:* Not all of the following reactions have been reported with Navane. However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane (thiothixene) is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur, although it usually subsides with continuation of Navane therapy. The incidence of sedation appears to be similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane. Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudoparkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: Although not reported with Navane, certain antipsychotic agents have been associated with persistent dyskinesias. Tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leucocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

NOTE: Sudden deaths have occasionally be reported in patients who have received cert phenothiazine derivatives. In some cases the cau of death was apparently cardiac arrest or asphy due to failure of the cough reflex. In others, t cause could not be determined nor could it established that death was due to phenothiazi administration because safe conditions for its u have not been established.

Dosage and Administration. Dosage of Nav should be individually adjusted depending on chronicity and severity of the condition. In ge eral, small doses should be used initially a gradually increased to the optimal effective lev based on patient response.

Usage in children under 12 years of age is n recommended.

Navane Intramuscular Solution—For Intram cular Use Only. Where more rapid control a treatment of behavior is desirable, the intram cular form of Navane (thiothixene hydrochlori may be indicated. It is also of benefit where very nature of the patient's symptomatolo whether acute or chronic, renders oral administ tion impractical or even impossible.

For treatment of acute symptomatology or patients unable or unwilling to take oral me cation, the usual dose is 4 mg. of Navane Int muscular administered 2 to 4 times daily. Dos may be increased or decreased depending on sponse. Most patients are controlled on a to daily dosage of 16 to 20 mg. The maximum r ommended dosage is 30 mg./day. An oral fo should supplant the injectable form as soon possible. It may be necessary to adjust the dos when changing from the intramuscular to o dosage forms. Dosage recommendations Navane Capsules and Concentrate appear in following paragraphs.

Navane Capsules: Navane Concentrate—milder conditions, an initial dose of 2 mg. th times daily. If indicated, a subsequent increase 15 mg./day total daily dose is often effective.

In more severe conditions, an initial dose 5 mg. twice daily.

The usual optimal dose is 20 to 30 mg. da If indicated, an increase to 60 mg./day total d dose is often effective. Exceeding a total d dose of 60 mg. rarely increases the beneficial sponse.

Some patients have been successfully maintain on once-a-day Navane (thiothixene) therapy.

Overdosage. Manifestations include muscu twitching, drowsiness, and dizziness. Symptoms gross overdosage may include CNS depressi rigidity, weakness, torticollis, tremor, salivati dysphagia, disturbances of gait, or coma.

Treatment: Essentially symptomatic and s portive. For Navane oral, early gastric lav is helpful. For Navane oral and intramuscu keep patient under careful observation and m tain an open airway, since involvement of extrapyramidal system may produce dysphag and respiratory difficulty in severe overdos If hypotension occurs, the standard measures managing circulatory shock should be used (I fluids and/or vasoconstrictors).

If a vasoconstrictor is needed, levarterenol phenylephrine are the most suitable drugs. Ot pressor agents, including epinephrine, are not r ommended, since phenothiazine derivatives m reverse the usual pressor action of these ag and cause further lowering of blood press

If CNS depression is present, recommen stimulants include amphetamine, dextroamph mine, or caffeine and sodium benzoate. Picroto or pentylenetetrazol should be avoided. Extra ramidal symptoms may be treated with antip kinson drugs.

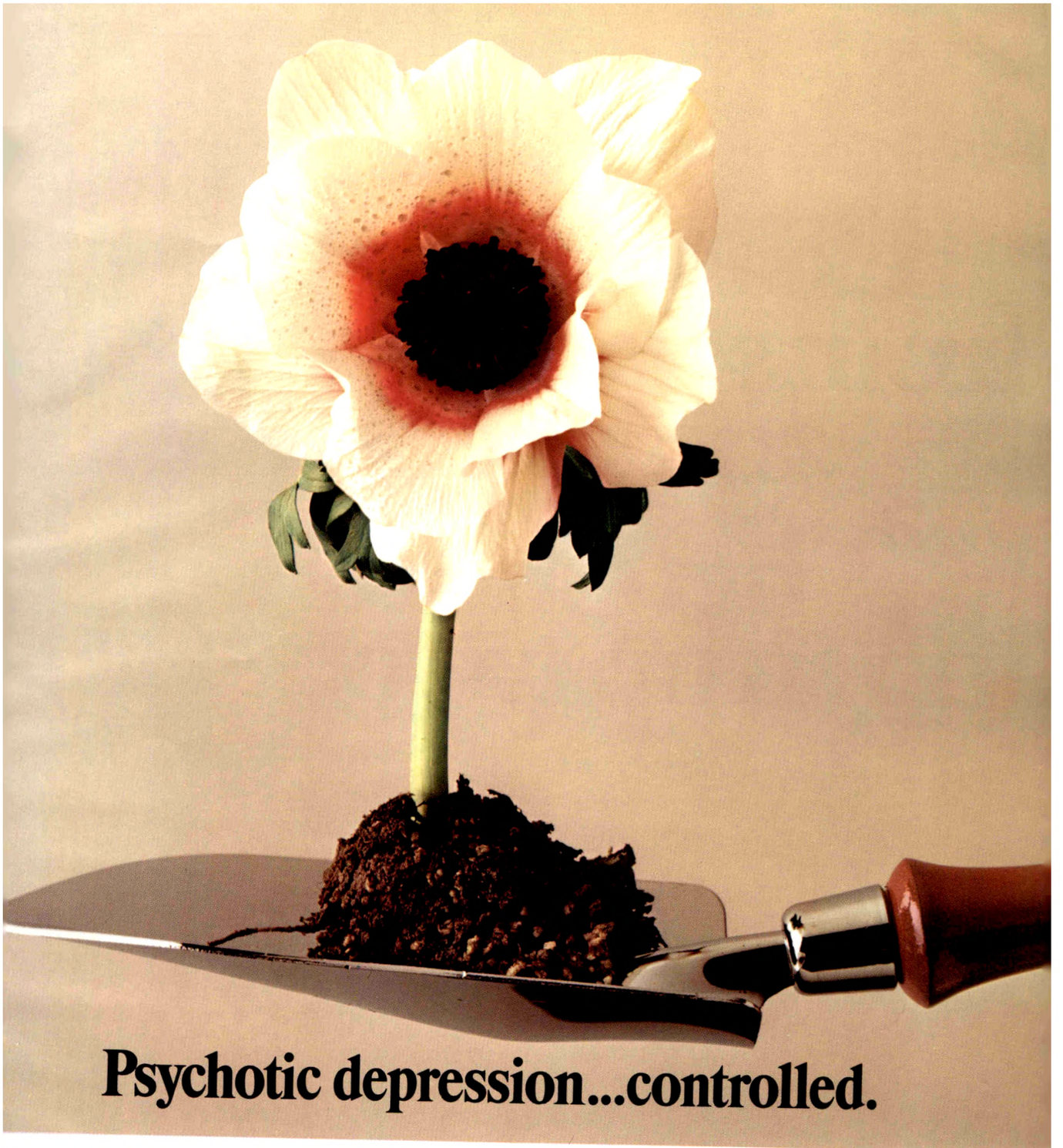
There are no data on the use of peritoneal hemodialysis, but they are known to be of li value in phenothiazine intoxication.

How Supplied. Navane (thiothixene) is availa as capsules containing 1 mg., 2 mg., 5 mg., 10 mg. in bottles of 100 and 1,000. Navane is a available as capsules containing 20 mg. of th thixene, in bottles of 100 and 500.

Navane (thiothixene hydrochloride) Conc trate is available in 120 cc. (4 oz.) bottles w an accompanying dropper calibrated at 2 mg mg., 5 mg., 6 mg., 8 mg. and 10 mg. Each contains thiothixene hydrochloride equivalent 5 mg. of thiothixene. Contains alcohol, U.S 7.0% v/v. (small loss unavoidable).

Navane (thiothixene hydrochloride) Intram cular Solution is available in a 2 cc. amber gl vial in packages of 10. Each cc. contains thioth ene hydrochloride equivalent to 2 mg. of thiothi ene, dextrose 5% w/v, benzyl alcohol 0.9% v

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



Psychotic depression...controlled.

Navane (thiothixene) helps reduce the intensity and frequency of depression as manifested in psychotic disorders. Mental and motor retardation may be replaced by an increasing interest in self and environment and a return to productive activity. Severe mood disorders may be relieved to encourage cooperation with therapy and daily routine. Navane...an effective anti-psychotic.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Navane®
(thiothixene) (thiothixene hydrochloride)

Capsules 1 mg., 2 mg., 5 mg., 10 mg. Concentrate 5 mg./cc., Intramuscular 2 mg./cc.

to help control psychotic depression

For prescribing information, including adverse reactions and contraindications, please see facing page of this advertisement.

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

In severe anxiety

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa. 19101

Please see important information on page after next.



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director

OSCAR ROZETT, M.D., Medical Administrator

GRANVILLE L. JONES, M.D., Director of Research

DONALD H. GENT, M.D., Chief, Adolescent Program

MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

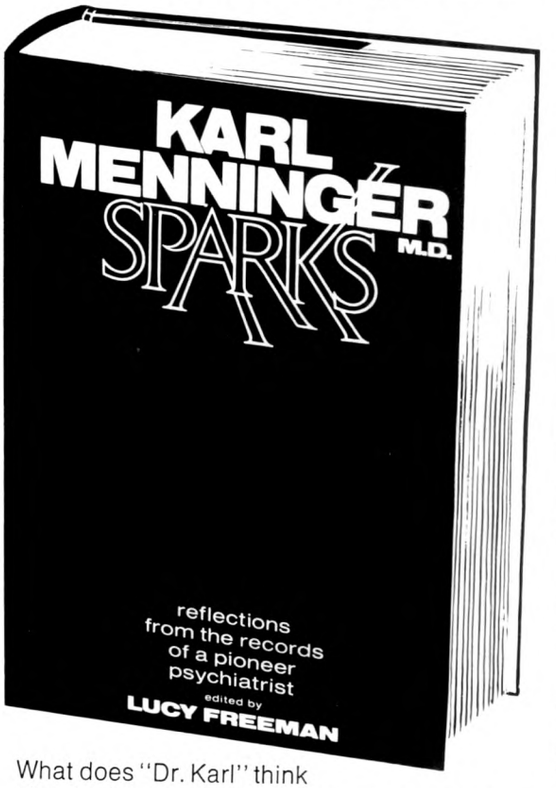
Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator

THE PURE GOLD OF OPINION...FROM DR. KARL MENNINGER



What does "Dr. Karl" think about when he's not working—or crusading? Everything in the world, including Kansas (he loves it), Freud, Schweitzer, "Deer Park" (he dislikes it), his parents, Kinsey, nature, politics, puzzles and earthworms. From his speeches, articles, *Reading Notes*, columns, letters and conversations, Lucy Freeman has created a full-fleshed portrait of the co-founder of the Menninger Clinic. And it is pure gold: irreverent, outspoken, sparkling.

SPARKS

KARL MENNINGER, M.D.

Edited by Lucy Freeman

$7.95 at your bookseller or from

THOMAS Y. CROWELL COMPANY, INC.
666 Fifth Avenue, New York, N.Y. 10019


R.S.V.P.

She just doesn't respond to things. No interest. No energy. Discouraged.

It may be mild depression. She needs help...and she needs it now.

Counsel and reassurance may suffice. But if you decide supportive medication is indicated, Ritalin can offer prompt benefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
(methylphenidate)
helps the patient respond in mild depression*

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available.
Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported.
Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

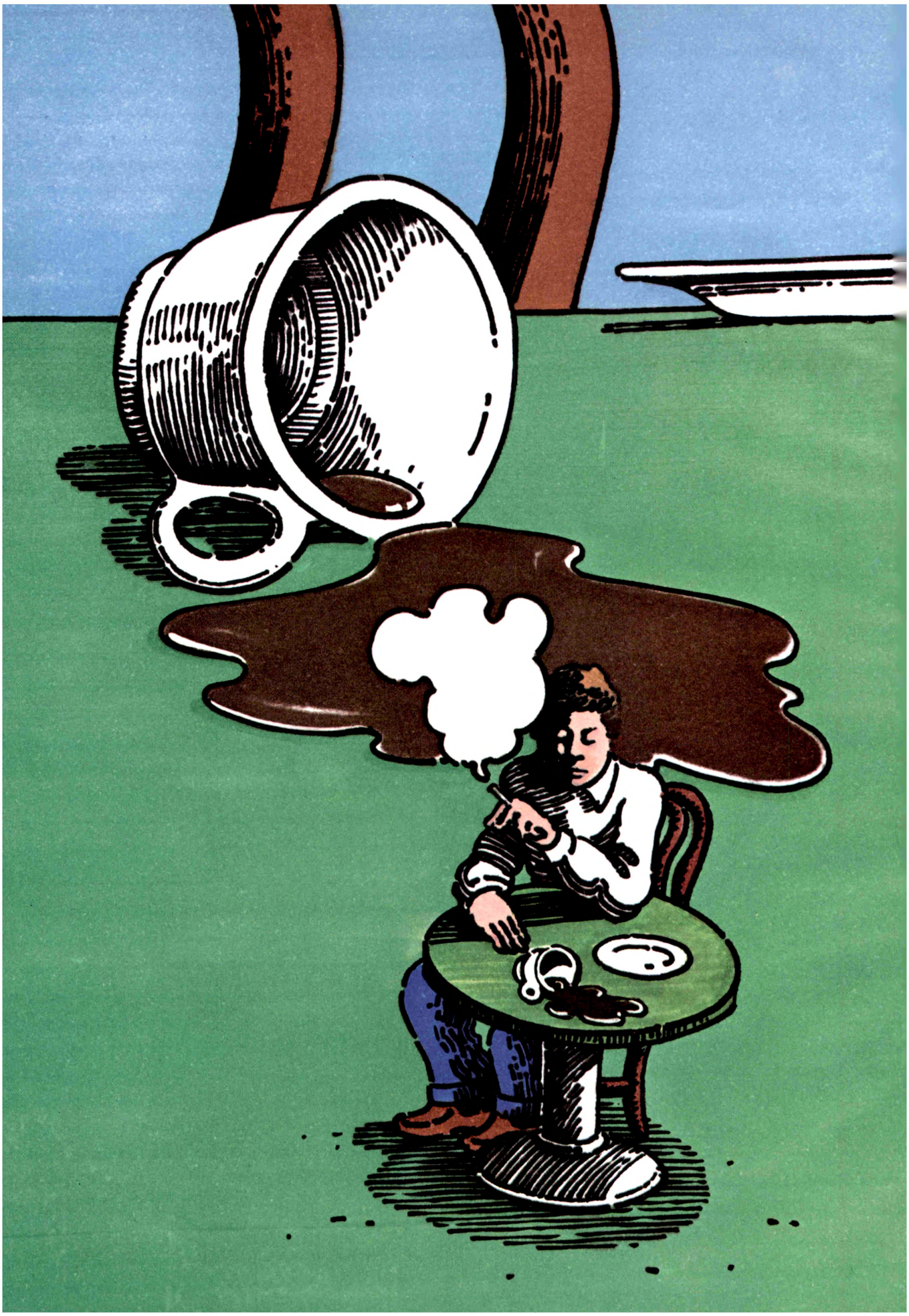
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

R/4783-1 17

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

CIBA

A51



HEL ETI N HIS PERSPECTIVE ON REALITY

With effective management of psychotic symptoms

- Decreases delusions, auditory and visual hallucinations
- Lessens unusual thought content, paranoid ideation
- Allays underlying fear, anxiety and tension
- Controls hostility
- Calms hyperactive behavior
- Reduces emotional withdrawal

Before prescribing, see complete prescribing information including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders. For control of the manifestations of manic-depressive illness (manic phase).

Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

©1967, 1968, 1969 SmithKline Corporation

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg., in bottles of 100; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg., in bottles of 50; Injection, 25 mg./ml.; Syrup, 10 mg./5 ml.; Suppositories, 25 mg. and 100 mg.; Concentrate, 30 mg./ml. and 100 mg./ml.

Smith Kline & French Laboratories
Division of SmithKline Corporation
Philadelphia, Pa. 19101

SK&F

THORAZINE®

brand of

C L P OMAZI E

Tablets:
50 mg. of the HCl


· nervous · anxious
· irritable
· fatigued
· restless nights
While you're calming her down with a tranquilizer...

treat what may be her real problem with

PREMARIN® BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

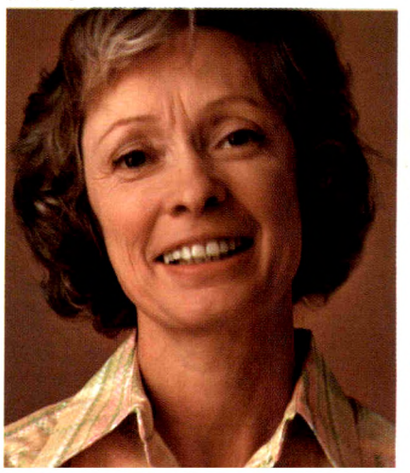
She's come to you in a highly emotional state, with complaints of anxiety, nervousness, insomnia, and depression. And treatment with a psychotherapeutic agent may be appropriate for immediate relief of symptoms.

But considering her age, and her irregular menses, such symptoms may indicate an underlying estrogen deficiency... and the need for additional, more comprehensive therapy.

PREMARIN, by offering sound specific natural estrogen replacement, can provide such therapy ...relieve estrogen-related emotional symptoms of the menopause by treating their cause. Anxiety and depression related to estrogen deficiency usually respond to replacement therapy in a relatively short time.[1,2] Other "psychogenic" symptoms such as headaches, crying spells, insomnia, feelings of weakness and fatigue may also be relieved.[1,3-5]

And in a large majority of patients, PREMARIN imparts a renewed sense of well-being.[6] At the same time, PREMARIN helps control hot flushes, sweats, genital tissue atrophy, and, in selected cases, helps retard postmenopausal osteoporotic bone degeneration.*

When there is uncertainty as to the origin of emotional symptoms in the menopausal woman, a therapeutic trial with PREMARIN helps relieve those complaints that are estrogen-related...while helping to identify those that aren't.[7]



for estrogen-related emotional symptoms of the menopause

See last page of advertisement for prescribing information.

*Conjugated Estrogens Tablets have been evaluated as "probably" effective for postmenopausal osteoporosis.

when her real problem is estrogen deficiency



PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

contains only natural estrogens

for estrogen-related emotional symptoms

BRIEF SUMMARY
(For full prescribing information, see package circular.)

PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding
(See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manif

Dosage and Administration: PREMARIN sho be administered cyclically (3 weeks of daily est gen and 1 week off) for all indications e cept selected cases of carcinoma and preventi of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cy cally. Adjust dosage upward or downwa according to severity of symptoms and respor of the patient. For maintenance, adjust dosage lowest level that will provide effective control.

If the patient has not menstruated within t last two months or more, cyclic administratior started arbitrarily. If the patient is menstruatir cyclic administration is started on day 5 of blee ing. If breakthrough bleeding (bleeding or sp ting during estrogen therapy) occurs, increa estrogen dosage as needed to stop bleeding. the following cycle, employ the dosage level us to stop breakthrough bleeding in the previo cycle. In subsequent cycles, the estrogen dosa is gradually reduced to the lowest level which v maintain the patient symptom-free.

Postmenopause—as a protective measu against estrogen deficiency-induced degener tive changes (*e.g.* osteoporosis, atrophic va nitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. da and cyclically. Adjust dosage to lowest effecti level.

Osteoporosis (to retard progression)—usu dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or wit out Pruritus—0.3 mg. to 1.25 mg. or more dai depending upon the tissue response of the in vidual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estr gens Tablets, U.S.P.) No. 865—Each *purple* tab contains 2.5 mg., in bottles of 100 and 1,00 No. 866—Each *yellow* tablet contains 1.25 m in bottles of 100 and 1,000. Also in unit dose pac age of 100. No. 867—Each *red* tablet contai 0.625 mg., in bottles of 100 and 1,000. No. 868 Each *green* tablet contains 0.3 mg., in bottles 100 and 1,000.

References: 1. Kerr, M.D.: Mod. Treatm. 5:5 (May) 1968. 2. Penningroth, R.P., and Tourn G.: Postgrad. Med. *46*:118 (July) 1969. Rhoades, F.P.: J. Amer. Geriat. Soc. *15*:346 (Ap 1967. 4. Astwood, E.B., in Goodman, L.S., a Gilman, A. (Eds.): The Pharmacological Basis Therapeutics, ed. 4, New York, The Macmill Company, 1970, chap. 69, p. 1538 ff. 5. Kupp man, H.S.: Med. Aspects of Hum. Sexuality *1* (Sept.) 1967. 6. Tramont, C.B.: Geriatrics *21*: (Nov.) 1966. 7. Kaufman, S.A., in Sturg S.H., and Taymore, M. (Eds.): Progress in Gyr cology, New York, Grune & Stratton, Inc., 19 vol. 5, p. 179.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

73

Clinical Notes on Group-Analytic Psychotherapy

By D. Wilfred Abse, *University of Virginia.* $6.50 (tnt.)

Group therapy is answering the need for psychiatric care for the large number of people in need of treatment—a number far exceeding that which qualified psychotherapists can handle on a one-to-one basis. This book meets the professional's need for an outline of the basic essentials for practicing group-analytic psychotherapy, and it offers criteria for determining when a patient would best benefit from such therapy. The author clearly defines group-analytic psychotherapy and outlines its history and present position in the field of mental health. He also suggests a method for determining the ideal group and the nature of the general pattern necessary for conducting group sessions. Dr. Abse builds a strong defense for group-analytic therapy, especially for the treatment of psychoneurotic patients who have serious difficulty with interpersonal relations.

Xenoglossy

By Ian Stevenson, *University of Virginia.* $8.50 (tnt.)

This is the first book written in English on xenoglossy—the ability of a person to speak a language other than his native one which he has not learned by any normal methods. Cases of xenoglossy are extremely rare. Even more rare are well-documented cases such as the major one presented in this volume. The book begins with an important and comprehensive review of all previously published instances of xenoglossy. The work then reports in detail a case of xenoglossy in which an American woman spoke Swedish. The hypnotized woman, here called T.E., underwent a transformation to a male personality which called itself Jensen and which spoke and understood Swedish in an intelligent way. The author follows with care the history of T.E., the background of Jensen, and concludes with good reasons to believe that the case cannot be fraudulent. Despite his support of its genuineness, he also discusses frankly alternative explanations for the case and other similar xenoglossy cases.

The Fear of Looking

or Scopophilic-exhibitionistic Conflicts

By David W. Allen, *University of California, San Francisco.* $7.95 (tnt.)

Scopophilia and exhibitionism have long been inadequately investigated even though a knowledge of them is crucial for understanding human behavior. This book brings scopophilia and exhibitionism out of obscurity and illustrates their importance in neuroses, in everyday life, and in treatment situations. It presents all the data and formulae available on scopophilia-exhibitionism and introduces the author's interpretations of its importance. Case histories are given which illustrate the importance of looking-showing influences in human behavior and demonstrate that scopophilic-exhibitionistic conflicts influence learning abilities, creativity, emotional distress, identity, and life styles. The book integrates information from such fields as neurophysiology, psychology, ethology, anthropology, and literature. It should interest not only psychiatrists and psychoanalysts but also sociologists, anthropologists, and artists. The author defines technical terms clearly so that the layman can easily read and understand the study.

Themes and Variations in European Psychiatry

An Anthology

Edited by Steven R. Hirsch, *Department of Psychiatry in Queen Mary's Hospital in Roehampton, England, and* Michael Shepherd, *University of London. Price to be announced.*

This volume of twenty-two papers by eighteen early influential explorers of psychiatry illustrates the breadth and depth of the mainstream of European psychiatric thinking. Only two of these papers have been printed before in English. This book will give English-speaking psychiatrists direct access to these important studies. The articles were chosen because they are still relevant to present-day psychiatric thinking, or because they represent a particularly characteristic concept or approach from another country which has no equal statement in English. The papers illustrate the approach of early clinical observers to issues that still pose major theoretical problems, such as the pathogenesis of psychiatric states including the role of psychogenesis; the distinction between pathoplastic and pathogenic factors and the status of the "reactive psychoses"; the limitations of clinical research; the phenomenology of individual syndromes and the distinction between them; the "paranoia" question; and several theoretical and conceptual frameworks that have been put forth by outstanding psychiatric thinkers.

ALSO OF INTEREST:

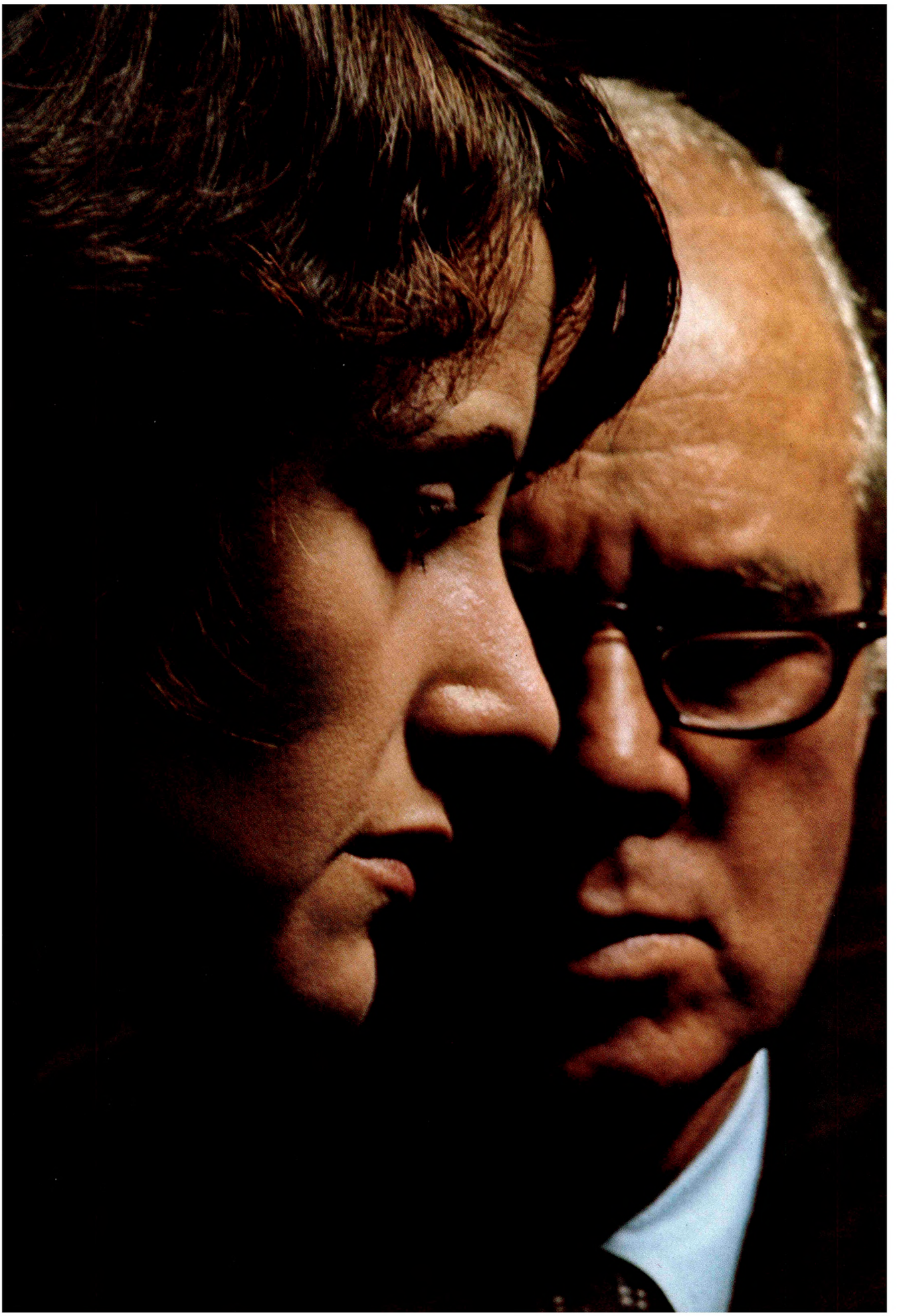
Speech and Reason: Language Disorder in Mental Disease and a Translation of Philipp Wegener's *The Life of Speech*

By D. Wilfred Abse, *University of Virginia.* $12.00

Telepathic Impressions: A Review and Report of Thirty-five New Cases

By Ian Stevenson, *University of Virginia.* $6.50

University Press of Virginia **Charlottesville**



Th TRIAVIL® Potential in the management of moderate to severe anxiety with depression

When time and talk are not enough...
The therapist is the primary catalyst for change in the psychotherapeutic relationship. However, when patients suffer from moderate to severe anxiety with depression, there are situations when TRIAVIL can often be a useful adjunct.

...TRIAVIL may help
There are three important benefits you may expect when TRIAVIL is part of the treatment program: (1) When symptoms of moderate to severe anxiety or agitation with depression are relieved, the patient may become more accessible and cooperative. (2) As somatic manifestations are controlled, attention may be focused on underlying causative factors. (3) Symptomatic relief may enable the patient to function more effectively in his daily life while your work with the patient progresses.

Since it is simpler to remember to take one tablet rather than several (particularly in multiple daily doses), your patients on TRIAVIL will be more likely to take proper doses of the medication. And, of course, economy is an added factor in therapy with TRIAVIL.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

MSD
MERCK SHARP & DOHME

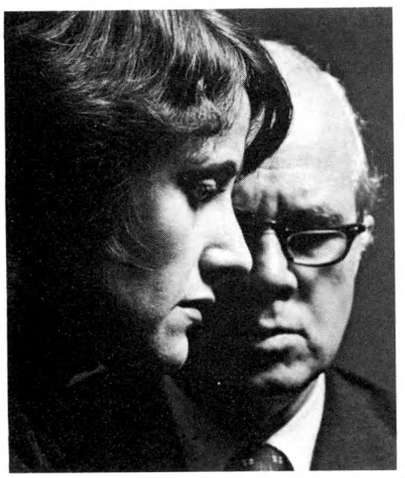
For a brief summary of prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression

TRIAVIL® (containing perphenazine and amitriptyline HCl)

an antidepressant tranquilizer

when patients exhibit moderate to marked anxiety
or agitation with symptoms of depression



TRIAVIL® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practic
when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or ir testinal obstruction.
A significant, not otherwise explained, rise in body temperatur may suggest individual intolerance to perphenazine, in whic case discontinue.
If hypotension develops, epinephrine should not be employec as its action is blocked and partially reversed by perphenazine Phenothiazines may potentiate the action of central nervous sys tem depressants (opiates, analgesics, antihistamines, barbitu rates, alcohol) and atropine. In concurrent therapy with any c these, TRIAVIL should be given in reduced dosage. May als potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed pa tients may experience a shift toward the manic phase if the are treated with an antidepressant. Patients with paranoid symp tomatology may have an exaggeration of such symptoms. Th tranquilizing effect of TRIAVIL seems to reduce the likelihoo of this effect. When amitriptyline HCl is given with anticholir ergic agents or sympathomimetic drugs, including epinephrin combined with local anesthetics, close supervision and carefu adjustment of dosages are required.
Caution is advised if patients receive large doses of ethchlorvy nol concurrently. Transient delirium has been reported in pa tients who were treated with 1 g of ethchlorvynol and 75-15 mg of amitriptyline HCl.
Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy Such treatment should be limited to patients for whom it is essential.
Discontinue several days before elective surgery if possible Elevation and lowering of blood sugar levels have both beer reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyper-reflexia, dystonia, akathisia, dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and EKG abnormalities (quinidine-like effect); reactivation of psychotic

ocesses; catatonic-like states; autonomic reactions, such as yness of the mouth or salivation, headache, anorexia, nausea, miting, constipation, obstipation, urinary frequency or incon- nence, blurred vision, nasal congestion, and a change in pulse te; hypnotic effects; pigmentary retinopathy; corneal and nticular pigmentation; occasional lassitude; muscle weakness; lld insomnia. Other adverse reactions reported with various henothiazine compounds include blood dyscrasias (pancyto- enia, thrombocytopenic purpura, leukopenia, agranulocytosis, osinophilia); liver damage (jaundice, biliary stasis); grand mal onvulsions; cerebral edema; polyphagia; photophobia; skin gmentation; and failure of ejaculation.

nitriptyline: Note: Listing includes a few reactions not reported r this drug, but which have occurred with other pharmacologi- ally similar tricyclic antidepressant drugs. *Cardiovascular:* ypotension; hypertension; tachycardia; palpitation; myocardial farction; arrhythmias; heart block; stroke. *CNS and Neuro- uscular:* Confusional states; disturbed concentration; dis- rientation; delusions; hallucinations; excitement; anxiety; rest- ssness; insomnia; nightmares; numbness, tingling, and aresthesias of the extremities; peripheral neuropathy; incoordi- ation; ataxia; tremors; seizures; alteration in EEG patterns; xtrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; urred vision; disturbance of accommodation; constipation; aralytic ileus; urinary retention; dilatation of urinary tract. *llergic:* Skin rash; urticaria; photosensitivity; edema of face nd tongue. *Hematologic:* Bone marrow depression including granulocytosis; leukopenia; eosinophilia; purpura; thrombo- ytopenia. *Gastrointestinal:* Nausea, epigastic distress; vomiting; norexia; stomatitis; peculiar taste; diarrhea; parotid swelling; lack tongue. *Endocrine:* Testicular swelling and gynecomastia n the male; breast enlargement and galactorrhea in the female; ncreased or decreased libido; elevated or lowered blood sugar evels. *Other:* Dizziness; weakness; fatigue; headache; weight ain or loss; increased perspiration; urinary frequency; mydria- is; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt essation after prolonged administration may produce nausea, eadache, and malaise. These are not indicative of addiction.

VERDOSAGE: The intravenous administration of 1-3 mg of hysostigmine salicylate has been reported to reverse the ymptoms of amitriptyline poisoning. On this basis, in se- ere overdosage with perphenazine-amitriptyline combinations, ymptomatic treatment of central anticholinergic effects with hysostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing nformation. Merck Sharp & Dohme, Division f Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance — vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

Anxiety Amelioration — in terms of motor, affective, autonomic and verbal phenomenon.

1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.

For the psychiatrist

The documented properties of DALMANE® (flurazepam HCl) for sleep

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

The properties of Dalmane have been carefully defined and thoroughly evaluated. Results of these investigations—many of which are cited here—have documented the effectiveness and relative safety of Dalmane when the etiology of insomnia indicates need for sleep medication.

Prompt sleep induction, effective through the night[1-13]

Consistently effective night after night[2,3,5,6,8-13]

Relative safety[11,14,15*]

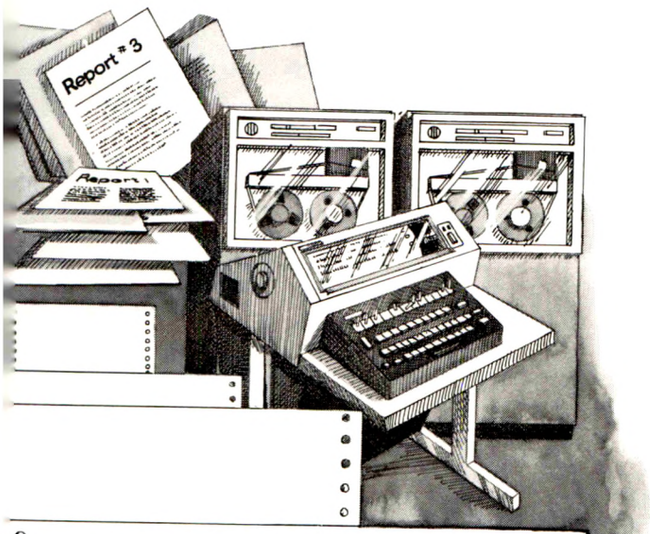
Usefulness in chronically anticoagulated patients[11]

1. Kales, A.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Philadelphia, Lippincott, 1969, p. 331. **2.** Kales, J., *et al.: Clin. Pharmacol. Ther., 12*:691, 1971. **3.** Jacobson, A., *et al.: Psychophysiology, 7*:345, 1970. **4.** Kales, A., and Kales, J.: *J.A.M.A., 213*:2229, 1970. **5.** Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970; and at 42nd Annual Scientific Meeting, Aerospace Med. Assoc., Houston, April 26-29, 1971. **6.** Karacan, I., *et al.:* "The Sleep Laboratory in the Investigation of Sleep and Sleep Disturbances," Scientific Exhibit presented at Amer. Psychiat. Assoc., Washington, D.C., May 3-7, 1971. **7.** Hartmann, E.: *Psychopharmacologia (Berl.), 12*:346, 1968. **8.** Dement, W. C.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **9.** Vogel, G. W.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **10.** Kales, A. and Kales, J. D.: *Pharmacol. Physicians, 4*:1, 1970. **11.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **12.** Kales, A., *et al.: Arch. Gen. Psychiat., 23*:226, 1970. **13.** Meyer, J. A.: "Flurazepam Hydrochloride for the Short-Term Treatment of Insomnia in the

*Generally, when adverse effects were reported clinically with Dalmane (flurazepam HCl), they were mild and infrequent. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most often, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

.ittle "hang-over" effect on wakening[11,14]

ospitalized Post-Surgical Patient," Scientific Exhibit esented at AAGP, San Francisco, Calif., Sept. 28-Oct. 1970. **14.** Zimmerman, A. M.: *Curr. Ther. Res., 13*:18, 71. **15.** Greenblatt, D., and Shader, R.: *Ann. Intern. ed., 77*:91, 1972.



Data about Dalmane (flurazepam HCl) on request

The references cited constitute only a part of the Dalmane bibliography. Additional data are available through the Roche Professional Services Department. Augmenting this service is RETRIEVE, a computer-operated data retrieval system which screens data from the published English language papers on Dalmane to help provide rapid answers to your specific questions. Coded into the computerized index are parameters that include patient age, sex, condition; product dose, side effect, frequency of administration; other medications or therapy; length, type and size of study, and pharmacology.

For specific answers to any questions you might have about Dalmane, write or call: Roche Professional Services Department, Roche Laboratories, Nutley, N.J. 07110. Telephone: (201) 235-2355.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MOVING?

PLEASE NOTIFY US 6 WEEKS IN ADVANCE

Change of address or name for THE AMERICAN JOURNAL OF PSYCHIATRY and/or PSYCHIATRIC NEWS. Please use only one address for APA mailings. Thank you.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS OR NAME:
(The number of characters indicated include spaces.)

APA IDENTIFICATION NO. (6 characters)

NAME: (24 characters)

(last) (first) (middle initial)

STREET ADDRESS: line #1 (24 characters)

STREET ADDRESS: line #2 (24 characters)

CITY: (16 characters)

STATE: (2 characters)

ZIP: (7 characters)

MAIL TO:

Division of Manpower Research
and Development
AMERICAN PSYCHIATRIC ASSOCIATION
1700 Eighteenth St., N.W.
Washington, D. C. 20009

INDEX TO ADVERTISERS

October 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

AYERST
Premarin A54–A56

CIBA PHARMACEUTICAL COMPANY
Ritalin A50–A51
Ritalin MBD A28–A29

THOMAS Y. CROWELL COMPANY, INC. A49

DEVEREUX FOUNDATION C4

EMPLOYMENT OPPORTUNITIES A16, A65

KNOLL PHARMACEUTICAL
Akineton A35

LAKESIDE LABORATORIES
Norpramin A66–C3

LEDERLE
Stresstabs A21
Artane A32–A33

McNEIL LABORATORIES, INC.
Haldol A17–A18

MERCK SHARP & DOHME
Cogentin A14–A15
Elavil A30–A31
Triavil A58–A61
Vivactil A36–A37

OXFORD UNIVERSITY PRESS A25

PENNWALT CORPORATION
Kolyum, Adapin A39–A42

PFIZER, INC.
Sinequan A22–A24
ROERIG DIVISION
Navane A43–A45

REUBEN REITER, ScD. INC.
Electrostimulators A20

ROCHE LABORATORIES
Dalmane A62–A63
Librium A6–A7

SANDOZ
Mellaril A34

SANITARIUMS AND PRIVATE HOSPITALS A49

SCHERING CORPORATION
Trilafon A11–A13

SMITH KLINE AND FRENCH LABORATORIES
Stelazine C2
Thorazine A52–A53

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A8–A10

UNIVERSITY PRESS OF VIRGINIA A57

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A19
Pertofrane A26–A27

WYETH LABORATORIES
Serax A46–A48

CHILD PSYCHIATRY FELLOWSHIPS

New, Board Approved, Child Psychiatry Fellowships offered in an innovative, established clinical program. Outpatient, Community Child Psychiatry and Residential Treatment offer opportunities for a variety of treatment techniques. Crisis intervention ("life-space" interviews); behavioral therapy, pharmacotherapy; individual, group and family treatment methods; dynamic, social and developmental psychiatry taught. Learning by independent study, seminars, supervised experiences. Administrative experiences and training may be arranged. Multi-disciplinary staff including; six child psychiatrists, pediatrician, pediatric neurologist, psychologist, social workers, special education teachers, speech therapist, occupational therapists, recreational therapists and other consultants.

Program affiliated with the University of Michigan and a variety of clinical settings including; community mental health centers, child guidance clinics, etc. Salaries negotiable. Contact: William E. Kirk, M.D., Director, York Woods Center, Box A2, Ypsilanti, Michigan 48197. Phone: (313) 434-3400.

AN EQUAL OPPORTUNITY EMPLOYER

PSYCHIATRISTS

Hutchings Psychiatric Center has position available for well-trained, energetic Psychiatrists with clinical teaching and research interests. We are developing a new facility as a major part of a balanced system of service for five counties in Central New York. Our team Psychiatrist leads a 50-man multi-disciplinary team with inpatient, day care, and outpatient facilities. Hutchings Psychiatric Center is adjacent to Upstate Medical Center, and Syracuse University. Affiliated residents in psychiatry and family practice, as well as students in social work, rehabilitation, hospital administration, and psychiatric nursing provide teaching opportunities. A 14-man research staff is available for support of research interests.

Qualifications: Immediate openings are available for board eligible and board certified Psychiatrists. Salary range — $26,485 - $36,445 depending upon qualifications and experience.

Benefits: Vacation, Sick leave, personal leave, health insurance, dental insurance, New York State Retirement System, and major affiliation with S.U.N.Y. College of Medicine at Syracuse.

An Equal Opportunity Employer

Write or Call: Frank B. Soults, M.D., Clinical Director
Hutchings Psychiatric Center
708 Irving Avenue
Syracuse, New York 13210
Phone: (315) 473-4943

1974 APA Appointment Books Desk and Pocket-sized

The "week-at-a-glance" Desk Appointment Book and the Pocket-sized version, published by the American Psychiatric Association, provide a quick and organized reference to your weekly engagements. As an added feature, it contains a comprehensive list of organizations and agencies of interest to psychiatrists and mental health professionals—in most cases director's name, address, phone number and date of forthcoming annual meeting are included. Also, there's a section to keep important phone numbers.

The Pocket-sized Appointment Book is 4" × 7 1/2", which is small enough to tuck inside your jacket, purse, suitcase or briefcase.

Desk: $5.00 ea.
Pocket: $3.00 ea.
Both: $7.00

Order 10 or more books for your colleagues or as gifts for your friends and take advantage of the 10% discount. Desk: $4.50 ea., Pocket-size: $2.70 ea. (15% discount for 100 or more copies)

Please send me
_____copy(ies) **Desk Appointment Book,** @$5.00 ea. order #141.
_____copy(ies) **Pocket Appointment Book,** @$3.00 ea. order #141-1.
_____set(s) **Desk & Pocket Appointment Book,** @$7.00 a set, order #141-2.
(10% discount for 10-99 copies; 15% discount for 100 or more copies.)

☐ Bill Me ☐ Check Enclosed

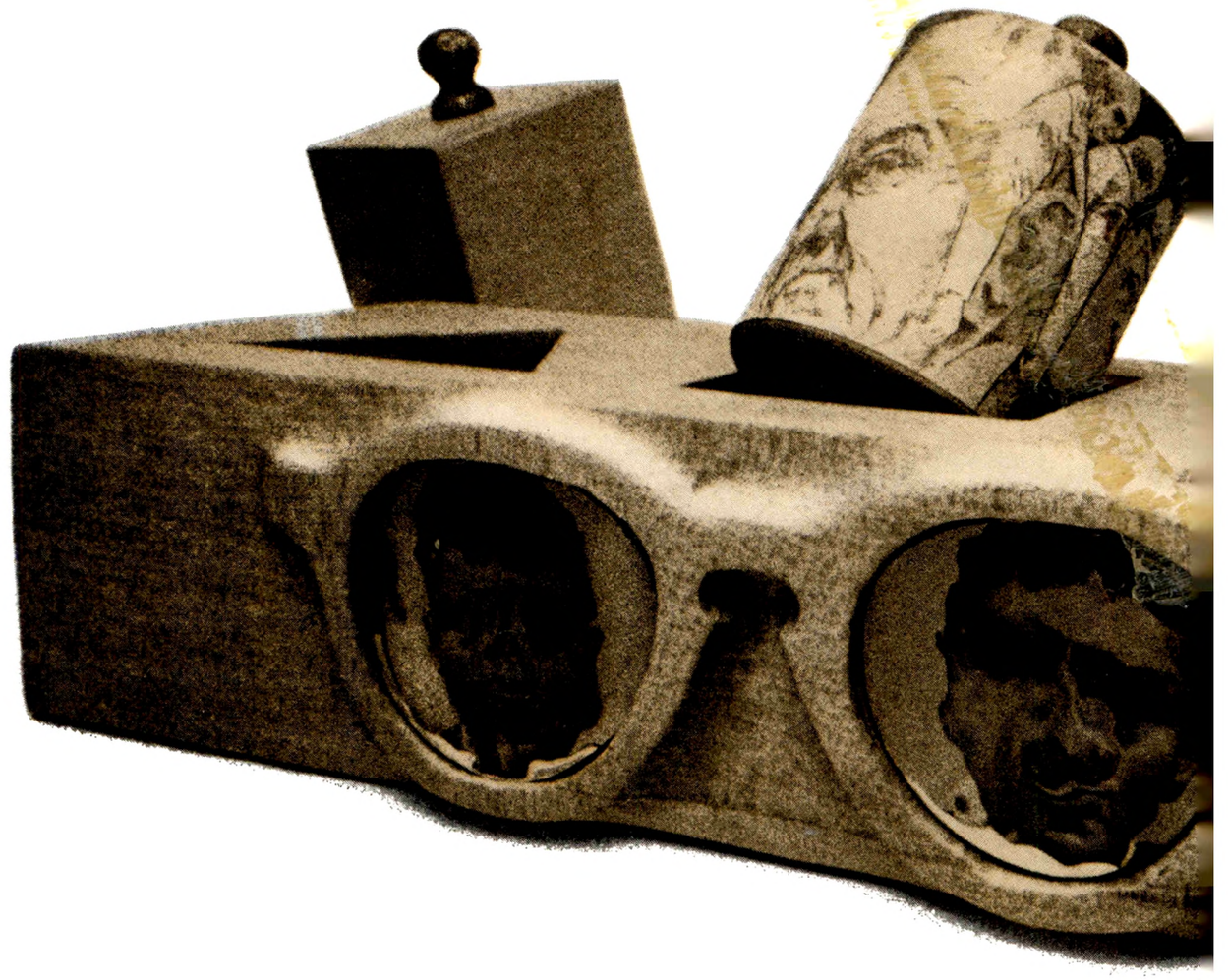
(Please Print)

Name _____
Address _____
City _____
State _____ Zip _____

Send Coupon to: Publications Sales
American Psychiatric Association
1700 Eighteenth St. N.W.
Washington, D.C. 20009

1073AJP

Help improve your depressed patients' ability to cope.



In Brief:

Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.

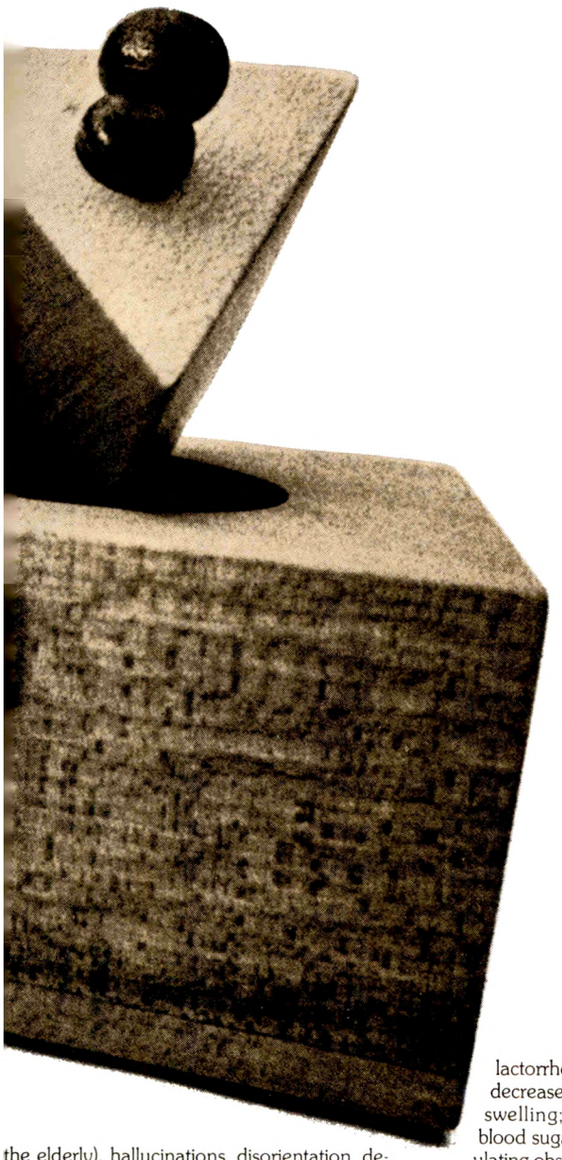
Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychos schizophrenic patients. Close supervision careful adjustment of dosage are required v this drug is given along with anticholinerg sympathomimetic drugs. While taking this c response to alcoholic beverages may be exa ated. There is limited clinical experience ir concurrent administration of ECT and an pressant drugs; thus, one should consider possibility of increased risk relative to ben Discontinue as soon as possible prior to ele surgery because of possible cardiovasc effects. Hypertensive episodes have b observed during surgery in patients on des mine hydrochloride. Leukocyte and differe counts should be performed in any patient develops fever and sore throat during the the drug should be discontinued if there is tropenia.

Adverse Reactions: *Cardiovascular:* hypo sion, hypertension, tachycardia, palpita arrhythmias, heart block, myocardial infarc stroke. *Psychiatric:* confusional states (espe



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

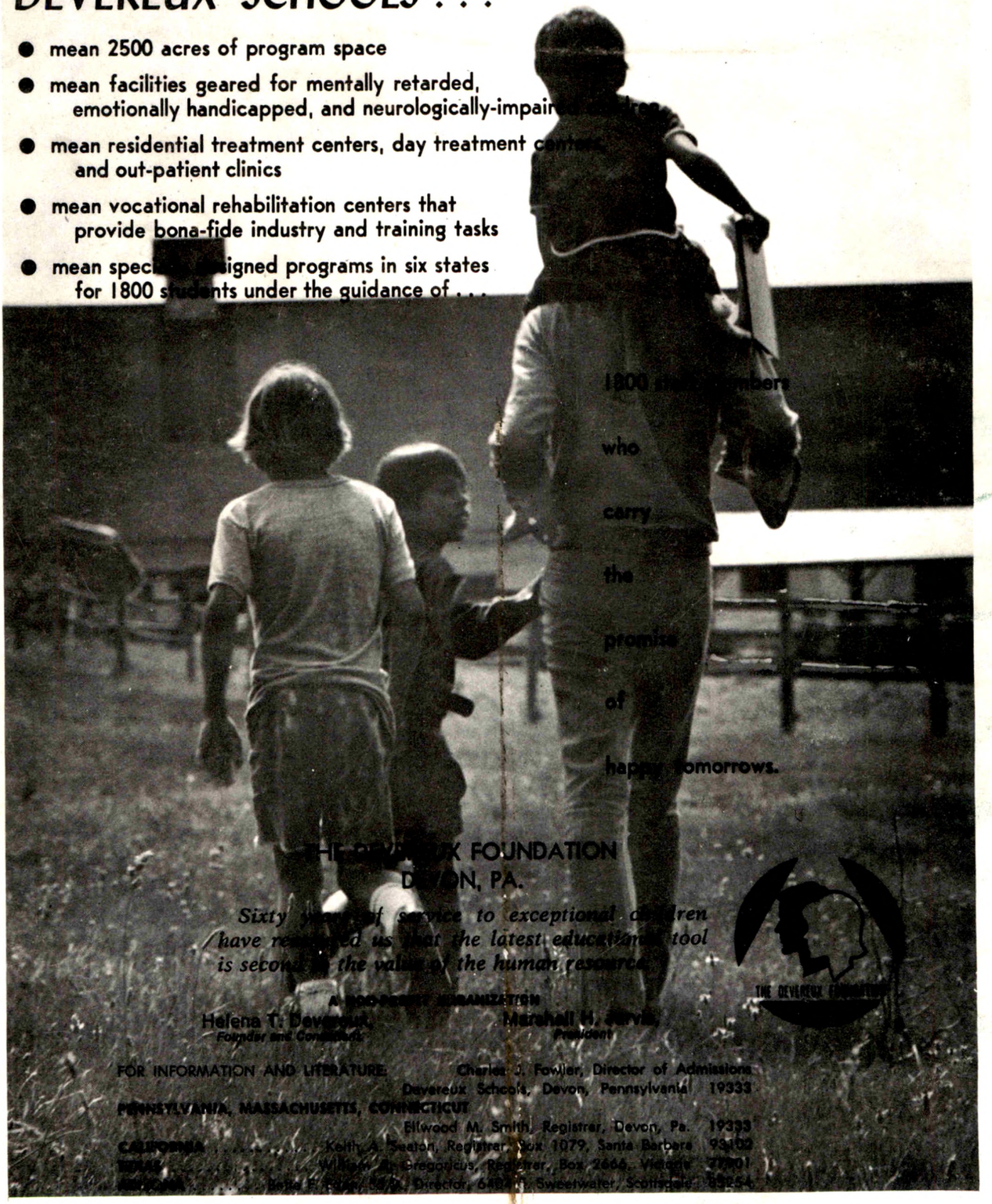
How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.*, sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.*, sugar coated tablets, light green, in bottles of 50, 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

DEVEREUX SCHOOLS . . .

- mean 2500 acres of program space
- mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impair[illegible]
- mean residential treatment centers, day treatment [illegible] and out-patient clinics
- mean vocational rehabilitation centers that provide bona-fide industry and training tasks
- mean spec[illegible]signed programs in six states for 1800 students under the guidance of . . .



1800 [illegible]mbers who carry the promise of happy tomorrows.

THE DEVEREUX FOUNDATION
DEVON, PA.

Sixty years of service to exceptional children have revealed us that the latest educational tool is second to the value of the human resource.

A NON-PROFIT ORGANIZATION

Helena T. Devereux, *Founder and Consultant*

Marshall H. Jarvis, *President*

FOR INFORMATION AND LITERATURE: Charles J. Fowler, Director of Admissions
Devereux Schools, Devon, Pennsylvania 19333

PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT
Ellwood M. Smith, Registrar, Devon, Pa. 19333

CALIFORNIA . . . . . Keith A. Seaton, Registrar, Box 1079, Santa Barbara 93102

TEXAS . . . . . William A. Gregorcyus, Registrar, Box 2666, Victoria 77901

ARIZONA . . . . . Betty P. Foley, M.A., Director, 6400 N. Sweetwater, Scottsdale 85254

Vol. 130, No. 11 November 1973

THE AMERICAN JOURNAL OF PSYCHIATRY

In this issue

Judd Marmor on The Future of Psychoanalytic Therapy

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

LIBRARY

SK&F PRESENTS

HAWAII '73

taped highlights of the 126th APA convention





Hawaii '73 features discussions and selections from papers on:

- medicine in China
- peer utilization review
- 1972 self-assessment program
- differential diagnosis of organic vs. functional illness
- history of psychiatry in Hawaii
- the manic patient
- psychiatry and the National High Blood Pressure Education Program

Ask your SK&F Representative for your cassette. Ask him for information on our products, too.

Smith Kline & French Laboratories, Division of SmithKline Corp., makers of:

Thorazine®
brand of
chlorpromazine
100 mg. tablets

Stelazine®
brand of
trifluoperazine HCl
(product of SK&F Co.)
2 mg. tablets

Eskalith®
brand of
lithium carbonate
300 mg. tablets

Parnate®
brand of
tranylcypromine
10 mg. tablets

Dexedrine® (II)
brand of
dextroamphetamine sulfate
5 mg. tablets

Compazine®
brand of
prochlorperazine
10 mg. tablets

SK-Bamate (IV)
brand of
meprobamate
200 mg. tablets

7.3.74

THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

e American Journal of Psychiatry,
:merly *The American Journal of Insanity,* is
blished monthly by the American Psychiatric
sociation. Editorial office: 1700 Eighteenth
reet, N.W., Washington, D.C. 20009;
ephone (202) 232-7878.

bscriptions: U.S. $15.00 per year, Canada and
uth America $15.75, other foreign $18.00;
gle issues: $1.75 plus postage.

PA members should direct changes of address
d communications about nonreceipt of the
urnal to the Manpower Division, American
ychiatric Association, 1700 Eighteenth Street,
W., Washington, D.C. 20009.

ommunications from nonmember subscribers
d all business communications should be
rected to Mr. Robert J. Lowe, Publications
rvices Division, at the same address.

dvertising representatives: Steven K. Herlitz,
c., 850 Third Avenue, New York, N.Y. 10022.

ype set by Bru-El Graphic, Inc., 5265 Port
oyal Road, Springfield, Va. 22151.

rinted by Dartmouth Printing Co., 69 Lyme
oad, Hanover, N.H. 03755.

econd class postage paid at Washington, D.C.,
d additional mailing offices.

ndexed in *Abstracts for Social Workers,*
'ological Abstracts, Chemical Abstracts,
umulative Index to Nursing Literature, Excerpta
Medica, Hospital Literature Index, Index
Medicus, International Nursing Index, Nutrition
bstracts, and *Psychological Abstracts.*

opyright©1973, the American Psychiatric
ssociation.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers
Assistant Managing Editor
Amy E. Shaughnessy
Senior Assistant Editor
Linda A. Loy
Assistant Editors
Laura M. Little
James Johnson
Christine H. Duewel
Editorial Assistant
Katherine P. Olinick
Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.

UNIVERSITY COLLEGE OF MEDICINE LIBRARY

THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 11 November 1973

1197 The Future of Psychoanalytic Therapy
Judd Marmor

1203 The Concept of Child Advocacy
John F. McDermott, Jr., William M. Bolman, Alfred M. Arensdorf, and Richard A. Markoff

1207 A Symposium: Should Homosexuality Be in the APA Nomenclature?
Robert J. Stoller, Judd Marmor, Irving Bieber, Ronald Gold, Charles W. Socarides, Richard Green, and Robert L. Spitzer

1217 Oral Contraceptives, Pyridoxine, and Depression
Frank Winston

1222 Subjects' Recent Life Changes and Coronary Heart Disease in Finland
Richard H. Rahe, Linda Bennett, Matti Romo, Pentti Siltanen, and Ransom J. Arthur

1227 Pediatric-Child Psychiatry Collaboration in a Health Maintenance Organization
Norton Garber

1232 Changing Human Service Delivery Systems: Their Influences on Psychiatric Training
Robert S. Daniels

1237 On the Stresses of Community Psychiatry, and Helping Residents To Survive Them
Andrew P. Morrison, Miles F. Shore, and Jerald Grobman

1242 Addicted Viet Nam Veterans: A Comparison of Self-Referred and System-Referred Samples
Edgar P. Nace, Andrew L. Meyers, and Joseph M. Rothberg

TOPICAL PAPERS: *Some Issues in Modern Living*

1246 Popular Attitudes and Beliefs About Tranquilizers
Dean I. Manheimer, Susan T. Davidson, Mitchell B. Balter, Glen D. Mellinger, Ira H. Cisin, and Hugh J. Parry

1253 The Road to Shangri-La Is Paved with Vitamins
Reuben Bitensky

1256 Physicians and the New Sexual Freedom
Iradj Siassi and Mivart Thomas

1257 Making Abortion Consultation Therapeutic
Cornelia Morrison Friedman

1262 Marriage, Family, and Parenthood
Henry Greenbaum

1265 Religious Delusions in Counter-Culture Patients
Peritz Levinson

1269 Opinions About Mental Illness and Political Ideology
Alexander Tolor

EDITORIAL

1273 The Psychiatrist and Family Planning
Eugene B. Brody

BRIEF COMMUNICATIONS

1275 What Is Psychiatry? A New Model of Service and Education
Alexander Z. Guiora and Saul I. Harrison

1278 Historical Background in Children with Affective Disorders
Donald H. McKnew, Jr., and Leon Cytryn

1280 Truth, Honesty, and the Therapeutic Process
Leon Salzman

1282 Once More: The Inaccuracy of Non-EEG Estimations of Sleep
Brian L. Weiss, Richard J. McPartland, and David J. Kupfer

1286 Imipramine Withdrawal: An Akathisia-Like Syndrome
Gregory L. Sathananthan and Samuel Gershon

1288 Incompetency To Stand Trial: Is Psychiatry Necessary?
Richard H. Bendt, Eugene J. Balcanoff, and Gregory S. Tragellis

1290 Teaching Psychiatry in the Context of Dying and Death
David Barton

IN MEMORIAM

1292 Ludwig von Bertalanffy, 1901–1972
William Gray

1293 LETTERS TO THE EDITOR

1298 BOOK REVIEWS

A57 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of each article: 60–100 words for regular articles, 40–60 words for Brief Communications. The author may prepare the precis himself or ask that the *Journal* staff prepare it, in which case the author may make any necessary changes on the galley proofs.

References. References should be typed double-spaced on a separate sheet of paper, to be attached at the end of the manuscript. They should be arranged according to their order of appearance in the text, where they should be indicated by numbers in parentheses. Reference citations should be restricted to closely pertinent papers; a complete review of the literature is rarely desirable, except in the case of review articles for which a special arrangement has been made with the Editor.

References should be typed in accordance with the style shown below for books and journal articles; chapters in books will be treated as journal articles with regard to capitalization. Up to three authors should be listed; one or more authors past the third will be designated "et al." Abbreviations of journal names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interaction between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, The Psychiatric Consultation. Edited by Mendel W, Solomon H. New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and figures should be sufficiently clear that the meaning of the data is understandable without reference to the text. See recent issues of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attached at the end of the manuscript. The data should be arranged so that columns of like material read down, not across.

A complete set of figures, preferably in the form of glossy prints, should accompany each of the two copies of the manuscript. Most figures will be reduced to about 3¼ inches in width, the column width of the *Journal*; all elements of a figure should be prepared to withstand this reduction. Graphs should be finished drawings not requiring further artwork. Authors are urged to engage the services of a professional in the preparation of figures. Authors may be required to meet the costs of any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for corrections after the paper has been scheduled for publication prompt return (preferably within 48 hours of receipt) is necessary to ensure publication in the assigned month. If an author expects to be away from his office for a long period of time after he has received the acceptance letter, he should inform the *Journal* office or arrange with a colleague to read the proofs. Authors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the galley proofs submitted to authors for correction. Reprints are usually mailed to authors about a month after publication of the article. Requests from others to order reprints should be directed to the Editor; inclusion of a letter of permission from the senior author and a brief statement of the intended use of the reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG, HERBERT KLEMMER, ALAN A. STONE, PERRY C. TALKINGTON

For two years: EWALD W. BUSSE, HENRIETTE R. KLEIN, MELVIN SABSHIN, JOHN R. SAUNDERS

For one year: ROBERT S. GARBER, JOHN E. NARDINI, IRVING PHILIPS, CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN

Constitution and By-Laws
WINFRED OVERHOLSER, JR.

Ethics
ROBERT A. MOORE

Membership
ALEXANDER LEVINE

Nominating
HOWARD P. ROME

Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN

History
DAVID F. MUSTO

Medical Education
HAROLD I. KAPLAN

School Consultation
SHELDON D. GLASS

Conference on Family Life Education
ARNOLD M. KALLEN

Graduate Education

Certification in Administrative Psychiatry
ARCHIE R. FOLEY

Research Training
FREDERIC G. WORDEN

Education of Physicians

Continuing Education Committee
ROBERT A. SENESCU

Continuing Education Task Force
JAMES NAIMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS

Psychiatry and the Law
STANLEY L. PORTNOW

Liaison with American Hospital Association
GERALD R. CLARK

Liaison with American College of Physicians
CHARLES P. NEUMANN

Psychiatric Nursing
WILLIAM E. STONE

Right to Treatment
BERNARD DIAMOND

Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN

Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER

Women in Psychiatry
NANCY A. ROESKE

Psychiatric Involvement in Family Planning
EUGENE B. BRODY

Psychosurgery
JOHN DONNELLY

Psychohistory
CHARLES HOFLING

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE

Drug Abuse
DANIEL X. FREEDMAN

Nomenclature and Statistics
HENRY BRILL

Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION

Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER

Lithium Therapy
IRVIN M. COHEN

Meditation
JAMES MORGAN

Effects of Television on Mental Health
JAMES H. RYAN

Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG

Joint Meeting in Australia 1975
ALFRED AUERBACK

Inter-American Council of Psychiatric Associations
HOWARD P. ROME

Psychological Aspects of Near Eastern Studies
WILLIAM D. DAVIDSON

Ethnocentricity Among Psychiatrists
RAMON PARRES

Transcultural Aspects of Mental Health of Children
JORGE M. VELASCO-ALZAGA

Liaison with International and Foreign Psychiatric Organizations
NATHAN S. KLINE

Joint Meeting with Scandinavian Psychiatric Societies
ROBERT S. GARBER

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON

Financing of Mental Health Care
WILLIAM H. GOLDMAN

Federal Government Health Services
STEWART BAKER

Childhood and Adolescence
VIOLA BERNARD

Private Psychiatric Hospitals
JOHN H. HOUCK

Suicide Prevention
MATHEW ROSS

Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD

APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON

Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE

Professional Standards Review Organizations
FRANK SULLIVAN

COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT

Program
H. KEITH H. BRODIE

Film Review
EDWARD A. MASON

Closed-Circuit TV Presentations
MILTON BERGER

Arrangements
BENJAMIN JEFFRIES

Conventions
ALEXANDER SIMON

Scientific Exhibits
ROBERT FROELICH

Awards for Scientific Exhibits
SARA DUBO

Public Information
JAMES P. CATTELL

Member Insurance and Retirement Plans
CHESTER TRENT

Trustees of APA Retirement Plan
SANFORD L. BILLET

House
DANIEL JAFFE

Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON

Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.

Isaac Ray Award
JOHN K. TORRENS

Manfred S. Guttmacher Award
JONAS R. RAPPEPORT

Hofheimer Prize
DONALD F. KLEIN

McGavin Award
NORBERT B. ENZER

Vestermark Prize
BERTRAM S. BROWN

Grants and Awards
JACK WEINBERG

Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL

Black Psychiatrists
JAMES P. COMER

Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT

Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ

Indian Affairs
MORTON BEISER

Comprehensive Health Planning
ROBERT L. WILLIAMS

Third-Party Intervention in Community Crises
FRANK OCHBERG

Legislative Network
HAYDEN H. DONAHUE

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD)

helps establish early therapeutic rapport

ontraindications: Known hypersensitivity; acute recovery phase following myocardial farction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe nvulsions, and deaths have occurred in patients receiving tricyclic antidepressant and AOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, minimum of 14 days should be allowed to elapse after the latter is discontinued. Protiptyline HCl should then be initiated cautiously with gradual increase in dosage until ptimum response is achieved.

arnings: May block the antihypertensive effect of guanethidine or similarly acting compunds. May impair mental and/or physical abilities required for the performance of hazardus tasks, such as operating machinery or driving a motor vehicle. Should be used with ution in patients with a history of seizures and, because of its autonomic activity, in tients with a tendency to urinary retention or increased intraocular tension.

achycardia and postural hypotension may occur more frequently than with other antipressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of e drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conuction time. Myocardial infarction and stroke have occurred with drugs of this class. n rare occasions, hyperthyroid patients or those receiving thyroid medication ay develop arrhythmias when this drug is given.

ge in Children: Not recommended for use in children because safety and effectiveness the pediatric age group have not been established.

ge in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, e in pregnant women, nursing mothers, or women who may become pregnant requires at possible benefits be weighed against possible hazards to mother and child.

ecautions: When protriptyline HCl is used to treat the depressive component of schizorenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, pressed patients may experience a shift toward the manic phase; paranoid delusions, th or without associated hostility, may be exaggerated. In any of these circumstances, it ay be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug ncurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive agitated patients.

hen given with anticholinergic agents or sympathomimetic drugs, including epinephrine mbined with local anesthetics, close supervision and careful adjustment of dosages are quired. May enhance response to alcohol and effects of barbiturates and other CNS pressants. Possibility of suicide in depressed patients remains during treatment and til significant remission occurs; this type of patient should not have easy access to rge quantities of the drug. Concurrent administration with electroshock therapy may crease hazards of therapy; such treatment should be limited to patients for whom it is ssential. Discontinue drug several days before elective surgery, if possible. Both elevation d lowering of blood sugar levels have been reported.

dverse Reactions: *Note:* Included in this listing are a few adverse reactions which have t been reported with this specific drug. However, the pharmacologic similarities among e tricyclic antidepressant drugs require that each of the reactions be considered when otriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation d anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

rdiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, rhythmias, heart block, stroke.

ychiatric: confusional states (especially in the elderly) with hallucinations, disorientaon, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightares; hypomania; exacerbation of psychosis.

eurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, emors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG atterns, tinnitus.

ntricholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed icturition, dilatation of the urinary tract.

llergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exosure to sunlight), edema (general, or of face and tongue), drug fever.

ematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; rombocytopenia.

astrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, tomatitis, abdominal cramps, black tongue.

ndocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; ncreased or decreased libido, impotence; testicular swelling; elevation or depression of lood sugar levels.

ther: jaundice (simulating obstructive); altered liver function; weight gain or loss; erspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and tigue; headache; parotid swelling; alopecia.

ithdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after rolonged therapy may produce nausea, headache, and malaise.

verdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been eported to reverse the symptoms of amitriptyline poisoning in humans. Animal studies ave shown that physostigmine also reverses certain toxic effects of protriptyline, but to lesser extent.

low Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit ackages of 100 and bottles of 100 and 1000.

or more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 88 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

The Country Place

LITCHFIELD, CONNECTICUT



THE COUNTRY PLACE is a residential community for the emotionally disturbed adult who has more insight than he can use, who knows how he should act but withdraws from action.

THE COUNTRY PLACE offers
a home where he is understood
a work place where he can cope with the demands
a community where he can find social identity

THE COUNTRY PLACE
provides team work in socially useful projects
self help through interaction in groups
exploration of existent reality

THE COUNTRY PLACE maintains a well-trained professional staff for individual and group therapy psychodrama, art, dance and music therapy, as well as sports and games

WEEK END WORKSHOPS for professionals interested in studying our method of helping the disturbed person in creating a new identity

Address inquiries to:

RENEE NELL, ED.D.
THE COUNTRY PLACE
Litchfield, Conn. 06759
Telephone: (203) 567-8763

McLean Hospital

announces

the opening of the McLean Hospital Children's Center for the diagnosis and treatment of children of all ages with emotional and learning problems.

The Center offers inpatient, outpatient, full and partial day care, aftercare and emergency services. A staff of psychiatrists, pediatricians, neurologists, psychologists social workers and other professionals work as a team to meet the various and special needs of each child.

Treatment includes individual and group psychotherapy pharmacotherapy, cognitive therapy and activity therapy. The psychoeducation unit provides special education through small classes. Treatment involves the family.

For more information, write or call:

McLean Hospital
Children's Center
115 Mill Street
Belmont, Massachusetts 02178
Telephone: 617-855-2804

The American Journal of Psychiatry

The December 1973 issue will feature

An Overview on

Trends in Psychiatric Research

by H. Keith H. Brodie

and Melvin Sabshin

We've got a new name



A (potassium gluconate-potassium chloride)

(but that's all).

KALYUM™ Liquid (potassium gluconate-potassium chloride), that's our old name. The name you knew us by.

We liked it. After all it's the Latin pronunciation for "potassium." And potassium supplementation is what we're all about.

So why change our name to KOLYUM™ Liquid (potassium gluconate-potassium chloride)?

It just happens that our old name could possibly be mistaken for the name of a large product in another therapeutic category. So we decided to eliminate any chance of confusion by changing *our* name.

But our name is all we changed. Kolyum (new name) is still the same good-tasting cherry flavored potassium supplement you trusted under the name of Kalyum.

So from now on—whenever you want effective potassium supplementation *without sodium and calories*, remember our new name: Kolyum Liquid.

Kolyum Liquid.

Potassium supplementation gets a neat new name.

PRESCRIBING INFORMATION

DESCRIPTION—Each 15 ml tablespoon provides 20 mEq. of potassium ion and 3.34 mEq. of chloride ion in a sugar free, cherry flavored vehicle.

INDICATION—Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

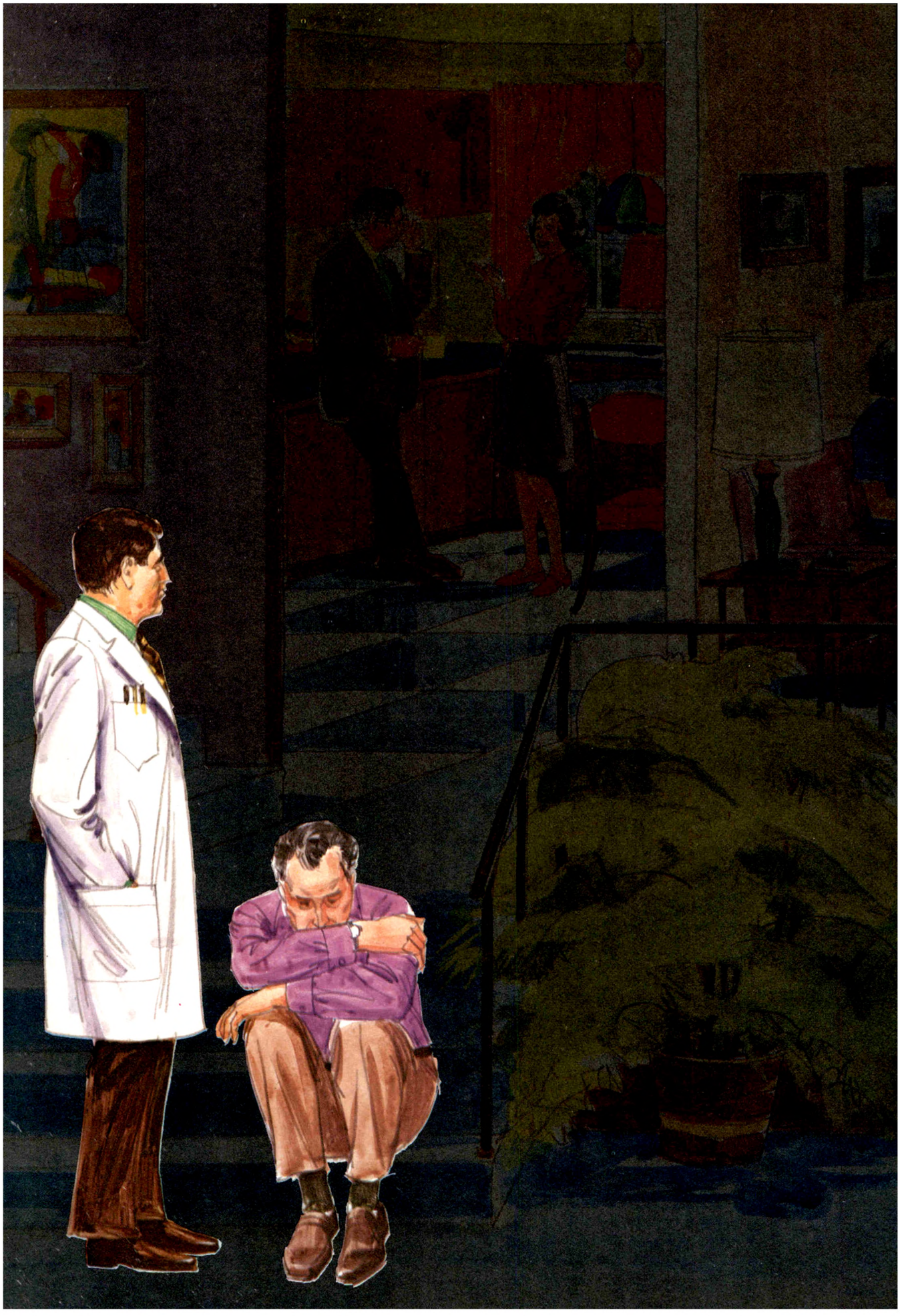
CONTRAINDICATIONS—Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

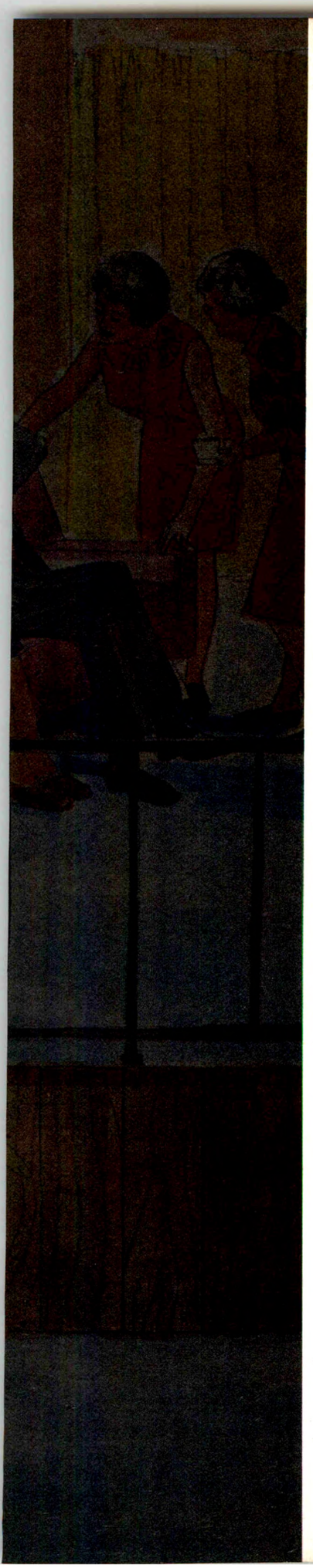
PRECAUTIONS—Potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease. Extreme caution should be used in patients receiving aldosterone antagonists or potassium sparing diuretics. In both cases potassium intoxication might occur.

ADVERSE REACTIONS—Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment and tall peaked T waves. DOSAGE—The usual adult dosage is one tablespoonful (15 ml.) in one fluid ounce or more of water twice daily. This supplies 40 mEq. of potassium ion which is the approximate minimal adult daily requirement, as well as 6.68 mEq. of chloride ion. Deviations from this recommendation may be indicated, since no average total daily dose can be defined but must be governed by close observation for clinical effects. OVERDOSAGE—Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours. SUPPLIED: Pints and gallons. Dispense in amber glass containers.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623





When the symptoms add up to depression

ADAPIN®
(Doxepin HCl)

opens the patient to your counsel

Biphasic action helps you "get to" the depressed patient quickly.

Depressed patients are often difficult to reach. Some are lethargic: withdrawn. And in others, agitation masks the underlying depression.

Adapin (doxepin HCl) works on either—or both—phases: depression/agitation-depression. That's how Adapin quickly opens the patient to your counsel. Lets you work with him as the drug works to lift his depressive symptoms (usually in two to three weeks).

Dosage flexibility allows you to choose therapeutic approach.

In situations where drowsiness is clinically undesirable, you can start the patient on 10 mg. Adapin t.i.d. for four days (without reduced therapeutic effect) titrating the dosage upward after that as indicated. In patients where you deem drowsiness to be a desirable effect, you can initiate therapy with 25 mg. or more t.i.d. as the clinical situation dictates.

Further, with Adapin, you can titrate dosage upward in 10 mg. increments, allowing you greater therapeutic flexibility.

Single entity; low possibility of "cross reactions."

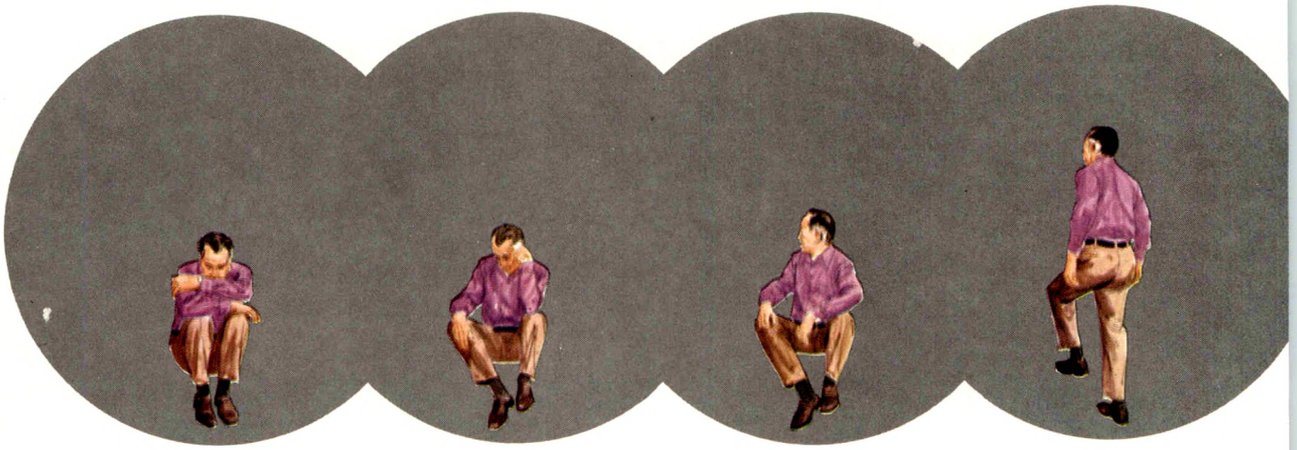
Adapin is single entity therapy. And there have been few reported instances of drug "cross reactions." In fact, one investigator reported no adverse interactions between doxepin HCl and alcohol, hypnotics, neuroleptics, antihypertensive drugs, oral hypoglycemic agents, or anticonvulsants.

No addictive potential. No reported withdrawal symptoms.

Well tolerated by patients (even the elderly) with concomitant organic disease.

Low starting dosage; fine dosage titration.

Please see following page for prescribing information.



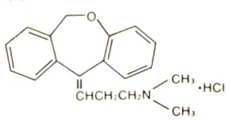
When the symptoms add up to depressio

ADAPIN®

(Doxepin HCl)

opens the patient to your counsel

COMPOSITION: Each Adapin capsule contains 10 mg., 25 mg., or 50 mg. of doxepin as the hydrochloride.



INDICATIONS: Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

CONTRAINDICATIONS: Adapin is contraindicated in patients with glaucoma or a tendency toward urinary retention, and in patients with demonstrated hypersensitivity to Adapin.

WARNINGS:

1. MAO inhibitors should be discontinued at least two weeks prior to cautious initiation of therapy with Adapin.
2. Adapin has not been evaluated in pregnant patients and should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.
3. Usage of Adapin in children under 12 years of age is not recommended because safe conditions for its use have not been established.

PRECAUTIONS: Patients should be warned of the possible occurrence of drowsiness and cautioned against driving a motor vehicle or operating hazardous machinery. The effects of alcoholic beverages may be increased. Since suicide is an inherent risk in depressed patients, they should be closely supervised. The possibility of activating or unmasking latent psychotic symptoms during therapy should be kept in mind. Significant blocking of the antihypertensive effect of guanethidine is exerted at dosages of 300 mg. per day or higher. Potentiation of norepinephrine response in animals has been noted, but this effect has not been observed in humans.

ADVERSE REACTIONS: Anticholinergic Effects—Dry mouth, blurred vision and constipation; CNS Effects—Drowsiness; Cardiovascular Effects—Tachycardia and hypotension. Infrequently: extrapyramidal symptoms, gastrointestinal reactions, secretory effects (increased sweating), weakness, dizziness, fatigue, weight gains, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE: 10 mg. to 25 mg. t.i.d. to start. An initial dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients. Usual optimum dosage is 75 to 150 mg. per day. In some patients with mild emotional symptomatology, including that which may accompany organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control. More severe anxiety and/or depression may require 50 mg. t.i.d. to start, gradually increased to 300 mg. per day.

OVERDOSAGE: Symptoms include an increase of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be pronounced tachycardia, hypotension and extrapyramidal symptoms. Treatment is essentially symptomatic with supportive therapy in the case of hypotension and excessive sedation.

SUPPLIED: Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 18-356-71) and 25 mg. (NDC 18-357-71) capsules in bottles of 100 and 50 mg. (NDC 18-358-65) capsules in bottles of 50. Caution: Federal law prohibits dispensing without a prescription.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14623

Charles C Thomas • Publisher

CHIZOPHRENIA: A Psychopharma-
ological Approach *by* **Thomas A.**
an, *McGill Univ., Montreal, Quebec,*
anada. '72, 144 pp., 26 il., 16 tables,
12.75

ELF-DISCOVERY THROUGH
ELF-EXPRESSION: Use of Art in
sychotherapy With Children and
dolescents *by* **Mala Betensky.** '73,
34 pp., 222 il. (32 in full color),
3.95

PIDEMIOLOGICAL PSYCHIATRY
Brian Cooper, *Univ. of London,*
ngland, and **H. G. Morgan,** *Univ. of*
ristol. Foreword by **Michael Shep-**
erd. '73, 232 pp., 13 il., 40 tables,
12.50

ENTAL DEVELOPMENT EVALU-
TION OF THE PEDIATRIC
ATIENT *by* **Lawrence C. Hartlage**
d **David G. Lucas,** *both of Indiana*
niv. Medical Center, Indianapolis.
3, 92 pp., 36 il., $6.50

PSYCHIATRIC STUDY OF
YTHS AND FAIRY TALES: Their
rigins, Meaning and Usefulness. An
nlarged and Thoroughly Revised
econd Edition of a Psychiatric Study
f Fairy Tales *by* **Julius E. Heuscher,**
tanford Univ., Stanford, California.
3, about 418 pp., 6 il.

EX CHANGE: The Achievement of
ender Identity by Feminized Trans-
exuals *by* **Thomas Kando,** *Univ. of*
alifornia, Riverside. '73, about 183
p., 12 tables

EFERRING THE PSYCHIATRIC
ATIENT: A Guide for the Physician
y **Larry R. Kimsey** *and* **Jean L.**
oberts. *Both of The Univ. of Texas,*
outhwestern Medical School at
allas. '73, 100 pp., $6.95

NDECENT EXPOSURE *by* **John M.**
Macdonald, *Univ. of Colorada School*
f Medicine. '73, 180 pp., 10 tables,
7.95

ATIENT POWER: The Development
f a Therapeutic Community in a
sychiatric Unit of a General Hospital
y **Philip M. Margolis,** *Univ. Hospital,*
nn Arbor, Michigan. Foreword by
Maxwell S. Jones. '73, about 192 pp.

THE THERAPY OF POETRY *by*
Molly Harrower, *Univ. of Florida,*
Gainesville. '72, 128 pp., $4.75

ART THERAPY IN A CHILDREN'S COMMUNITY: A Study of the Function of Art Therapy in the Treatment Program of Wiltwyck School for Boys (2nd Ptg.) *by* **Edith Kramer.** '73, 256 pp. (5 1/2 x 8 1/2), 34 il. (8 in full color), $10.75

The Neurosis of Our Time: ACTING OUT *compiled and edited by* **Donald S. Milman** *and* **George D. Goldman,** *both of Adelphi Univ., New York City. (22 Contributors)* '73, 388 pp., 1 il., 6 tables, $12.75

A PANORAMA OF SUICIDE: A Casebook of Psychological Autopsies *by* **G. Donald Niswander** *and* **Thomas M. Casey,** *both of New Hampshire Hospital, Concord, New Hampshire; and* **John A. Humphrey,** *Univ. of North Carolina, Greensboro.* '73, about 144 pp.

A PRACTICAL HANDBOOK OF PSYCHIATRY *edited by* **Joseph R. Novello,** *Univ. of Michigan Medical School, Ann Arbor. (17 Contributors)* '73, about 464 pp., 10 il., 47 tables

L-DOPA AND PARKINSONISM: A Psychological Assessment *by* **Manuel Riklan,** *Fordham Univ., Bronx, New York.* '73, 416 pp., 6 il., 17 tables, $15.75

LESBIANISM: A Study of Female Homosexuality *by* **David H. Rosen,** *Univ. of California School of Medicine, San Francisco. Foreword by* **Judd Marmor.** '73, about 120 pp., 30 il.

PSYCHOANALYSIS AND THE LAW *by* **C. G. Schoenfeld.** '73, 296 pp., $13.75

CHILDREN'S EXPERIENCE WITH DEATH *by* **Rose Zeligs.** '73, about 276 pp.

SURVIVORS OF SUICIDE *edited by* **Albert C. Cain,** *Univ. of Michigan, Ann Arbor. Foreword by* **Edwin S. Shneidman.** *(16 Contributors)* '72, 324 pp., 3 il., $14.75

DEPRESSIVE ILLNESS: Some Research Studies *edited by* **Brian M. Davies, Bernard J. Carroll** *and* **Robert M. Mowbray,** *all of Royal Melbourne Hospital, Victoria. (6 Contributors)* '72, 368 pp., 17 il., 88 tables, $19.50

GENETIC FACTORS IN "SCHIZOPHRENIA" *compiled and edited by* **Arnold R. Kaplan,** *Cleveland Psychiatric Institute, Ohio. Forewords by* **Arnold Sorsby** *and* **Newton E. Morton.** *(35 Contributors)* '72 724 pp. (7 x 10), 42 il., 91 tables, $43.00

HELP FOR THE DEPRESSED *by* **Samuel H. Kraines,** *Formerly, Univ. of Illinois Medical School, and* **Eloise S. Thetford,** *Chicago Teachers College. Both of Chicago.* '72, 272 pp., 9 il., $8.25 paper

WHY PEOPLE KILL THEMSELVES: A Summary of Research Findings on Suicidal Behavior *by* **David Lester,** *Stockton State College, Pomona, New Jersey.* '72, 368 pp., $14.75

PETS AND HUMAN DEVELOPMENT *by* **Boris M. Levinson,** *Yeshiva Univ., New York City.* '72, 256 pp., 13 tables, $10.50

EVALUATION AND MANAGEMENT OF THE VIOLENT PATIENT: Guidelines in the Hospital and Institution *by* **John R. Lion,** *Univ. of Maryland School of Medicine, Baltimore.* '72, 88 pp., $6.00

MAN FOR HUMANITY: On Concordance vs Discord in Human Behavior *edited by* **Jules H. Masserman,** *Northwestern Univ., Chicago, and* **John J. Schwab,** *Univ. of Florida, Gainesville. (28 Contributors)* '72, 384 pp., 1 table, $20.50

ENVIRONMENT AND HUMAN EFFICIENCY (2nd Ptg.) *by* **E. C. Poulton,** *Medical Research Council, Cambridge, England.* '72, 336 pp. (6 3/4 x 9 3/4), 74 il., 11 tables, $15.50

ANGER: Psychology, Physiology, Pathology *by* **Frederic R. Stearns.** '72, 84 pp., $6.50

LAUGHING: Physiology, Pathophysiology, Psychology, Pathopsychology and Development *by* **Frederic R. Stearns.** '72, 84 pp., $6.50

UNDERSTANDING THROUGH COMMUNICATION: Structured Experiments in Self-Exploration *by* **Lois Timmins,** *Timberlawn Psychiatric Hospital, Dallas, Texas. Foreword by* **Howard M. Burkett.** '72, 336 pp., $11.75

301-327 East Lawrence Ave., • Springfield • Illinois • 62717



recovery room

The psychiatric setting... and the role of TRIAVIL®.

Change, growth, and insight can flourish in this private and protected place, for seldom is the doctor-patient relationship more meaningful than in this psychotherapeutic setting. There are situations and stages, however, when time and talk are not enough... when the careful use of a psychotropic agent such as TRIAVIL can help accelerate recovery. Specifically, when TRIAVIL is part of the treatment program, you may anticipate these important therapeutic benefits:

The TRIAVIL Potential

1. By relieving moderate to severe anxiety or agitation with depression, the patient may become more accessible and cooperative.
2. As somatic manifestations of anxiety and depression are controlled, attention may be focused on the underlying factors of the condition.
3. While the psychotherapeutic process proceeds, symptomatic relief may enable the patient to function more effectively in his daily activities.

In addition, since TRIAVIL combines a tranquilizer with an antidepressant, confused and troubled patients need remember to take only one type of tablet, rather than two. And patients are offered economical therapy compared to a tranquilizer and an antidepressant prescribed separately.

Treatment with TRIAVIL a balanced view.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential, particularly until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

a tranquilizer – antidepressant

Triavil®

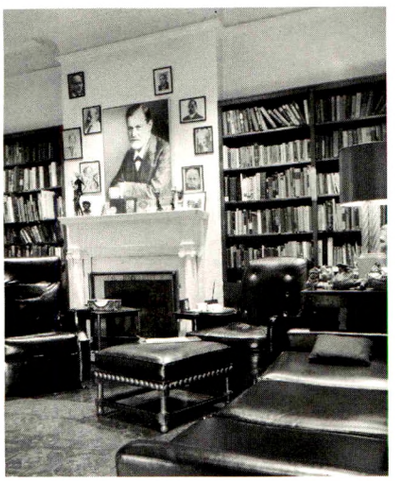
a potential aid in the psychotherapeutic process when patients exhibit moderate to marked anxiety or agitation with depression

containing perphenazine and amitriptyline HCl

MSD
MERCK SHARP & DOHME

For additional prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety
or agitation with depression



Triavil® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practice
when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.
A significant, not otherwise explained, rise in body temperatur may suggest individual intolerance to perphenazine, in whic case discontinue.
If hypotension develops, epinephrine should not be employed as its action is blocked and partially reversed by perphenazine
Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any o these, TRIAVIL should be given in reduced dosage. May als potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed pa tients may experience a shift toward the manic phase if the are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. Th tranquilizing effect of TRIAVIL seems to reduce the likelihoo of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrin combined with local anesthetics, close supervision and carefu adjustment of dosages are required.
Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in pa tients who were treated with 1 g of ethchlorvynol and 75-15 mg of amitriptyline HCl.
Amitriptyline HCl may enhance the response to alcohol and th effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshoc therapy may increase the hazards associated with such therapy Such treatment should be limited to patients for whom it i essential.
Discontinue several days before elective surgery if possible Elevation and lowering of blood sugar levels have both bee reported.

ADVERSE REACTIONS: Similar to those reported with eithe constituent alone.
Perphenazine: Side effects may be any of those reported wit phenothiazine drugs: extrapyramidal symptoms (opisthotonus oculogyric crisis, hyper-reflexia, dystonia, akathisia, dyskinesia ataxia, parkinsonism) can usually be controlled by the cor comitant use of effective antiparkinsonian drugs and/or by re duction in dosage, but sometimes persist after discontinuation o the phenothiazine; skin disorders (photosensitivity, itching erythema, urticaria, eczema, up to exfoliative dermatitis); othe allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reverse epinephrine effect; hyperglycemia; endocrine disturbances (lac tation, galactorrhea, gynecomastia, disturbances of menstrua cycle); altered cerebrospinal fluid proteins; paradoxical excite ment; hypertension, hypotension, tachycardia, and EKG ab normalities (quinidine-like effect); reactivation of psychoti

rocesses; catatonic-like states; autonomic reactions, such as ryness of the mouth or salivation, headache, anorexia, nausea, omiting, constipation, obstipation, urinary frequency or incon- nence, blurred vision, nasal congestion, and a change in pulse ate; hypnotic effects; pigmentary retinopathy; corneal and enticular pigmentation; occasional lassitude; muscle weakness; nild insomnia. Other adverse reactions reported with various henothiazine compounds include blood dyscrasias (pancyto- enia, thrombocytopenic purpura, leukopenia, agranulocytosis, osinophilia); liver damage (jaundice, biliary stasis); grand mal onvulsions; cerebral edema; polyphagia; photophobia; skin igmentation; and failure of ejaculation.

mitriptyline: Note: Listing includes a few reactions not reported or this drug, but which have occurred with other pharmacologi- ally similar tricyclic antidepressant drugs. *Cardiovascular:* lypotension; hypertension; tachycardia; palpitation; myocardial nfarction; arrhythmias; heart block; stroke. *CNS and Neuro- nuscular:* Confusional states; disturbed concentration; dis- rientation; delusions; hallucinations; excitement; anxiety; rest- essness; insomnia; nightmares; numbness, tingling, and aresthesias of the extremities; peripheral neuropathy; incoordi- ation; ataxia; tremors; seizures; alteration in EEG patterns; xtrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; lurred vision; disturbance of accommodation; constipation; aralytic ileus; urinary retention; dilatation of urinary tract. *llergic:* Skin rash; urticaria; photosensitivity; edema of face nd tongue. *Hematologic:* Bone marrow depression including granulocytosis; leukopenia; eosinophilia; purpura; thrombo- ytopenia. *Gastrointestinal:* Nausea, epigastic distress; vomiting; norexia; stomatitis; peculiar taste; diarrhea; parotid swelling; lack tongue. *Endocrine:* Testicular swelling and gynecomastia n the male; breast eniargement and galactorrhea in the female; ncreased or decreased libido; elevated or lowered blood sugar evels. *Other:* Dizziness; weakness; fatigue; headache; weight ain or loss; increased perspiration; urinary frequency; mydria- is; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt essation after prolonged administration may produce nausea, eadache, and malaise. These are not indicative of addiction.

VERDOSAGE: The intravenous administration of 1-3 mg of hysostigmine salicylate has been reported to reverse the ymptoms of amitriptyline poisoning. On this basis, in se- ere overdosage with perphenazine-amitriptyline combinations, ymptomatic treatment of central anticholinergic effects with hysostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance—vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

Anxiety Amelioration—in terms of motor, affective, autonomic and verbal phenomenon.

1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.

R.S.V.P.



She just doesn't respond to
ings. No interest. No energy.
iscouraged.

It may be mild depression.
ne needs help...and she needs it
ow.

Counsel and reassurance
ay suffice. But if you decide
pportive medication is indi-
ted, Ritalin can offer prompt
enefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
methylphenidate)
helps the patient
espond in mild depression*

talin® hydrochloride ©
ethylphenidate hydrochloride)

BLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, DA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

NTRAINDICATIONS
rked anxiety, tension, and agitation, since alin may aggravate these symptoms. Also ntraindicated in patients known to be persensitive to the drug and in patients with ucoma.

RNINGS
alin should not be used in children under years, since safety and efficacy in this age up have not been established.
fficient data on safety and efficacy of long-m use of Ritalin in children with minimal in dysfunction are not yet available.
hough a causal relationship has not been ablished, suppression of growth (*ie*, weight n and/or height) has been reported with g-term use of stimulants in children. erefore, children requiring long-term rapy should be carefully monitored.
alin should not be used for severe depres-n of either exogenous or endogenous origin or the prevention of normal fatigue states.
alin may lower the convulsive threshold in ients with or without prior seizures; with or out prior EEG abnormalities, even in ence of seizures. Safe concomitant use of iconvulsants and Ritalin has not been ablished. If seizures occur, Ritalin should discontinued.
cautiously in patients with hypertension. od pressure should be monitored at appro-ite intervals in all patients taking Ritalin, ecially those with hypertension.
g Interactions
lin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4763-1 17

s drug has been evaluated as possibly effective for this indication. See brief prescribing information.

C I B A

This man will self-destruct...



ALCOHOLISM
shortens the abuser's life-span by 10 to 12 years*

Private problem/ Public menace

Besides having a shortened life expectancy, the alcoholic is roughly twice as likely to develop hypertension, ulcers, or cerebrovascular disease; 29 times as likely to develop cirrhosis of the liver; and 58 times as apt to commit suicide as the nonalcoholic. Moreover, an estimated 28,000 automobile deaths each year involve drinking drivers, and alcohol addiction, directly or indirectly, causes almost half of all the crimes in this country.

ANTABUSE® (disulfiram) when he's ready for help

For almost 25 years, ANTABUSE has proved its effectiveness as a medical adjunct in the management of alcoholics who are motivated to recover. ANTABUSE offers strong deterrent action to help them maintain sobriety and participate in a total treatment program, including supportive measures such as psychotherapy and/or concerned people, agencies, or organizations (e.g., Alcoholics Anonymous).

When you prescribe ANTABUSE and the alcoholic patient accepts it, he strengthens his resolve to stop drinking with each daily tablet he takes. If he drinks while the ANTABUSE effect remains in his bloodstream, he will become intensely ill. **The patient must be given a clear and detailed account of the effects of ingesting even a small amount of alcohol after he has taken ANTABUSE, and must be told that such effects may occur even up to 14 days after the last dose.** This factor deters impulsive drinking, shores up the patient's resolve, and helps enforce his sobriety. And, since ANTABUSE is nonhabituating, there's no chance of cross-addiction... a decided advantage in helping the motivated alcoholic stay on a long-term rehabilitation program.

*According to the National Institute on Alcohol Abuse and Alcoholism, alcohol abusers are estimated to shorten their life-span by an average of 10 to 12 years.

BRIEF SUMMARY
(For full prescribing information, see package circular.)

ANTABUSE® (disulfiram) In Alcoholism

INDICATION: ANTABUSE is an aid in the management of selected chronic alcoholic patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage. (Used alone, without proper motivation and without supportive therapy, ANTABUSE is not a cure for alcoholism, and it is unlikely that it will have more than a brief effect on the drinking pattern of the chronic alcoholic.)

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, *e.g.* cough syrups, tonics, and the like, should not be given ANTABUSE.

ANTABUSE is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, or hypersensitivity.

ANTABUSE®
Brand of DISULFIRAM

A strong deterrent for the alcoholic who doesn't want to drink

WARNINGS: ANTABUSE should never be administered to a patient when he is in a state of alcohol intoxication or without his full knowledge.

The physician should instruct relatives accordingly.

The patient must be fully informed of the ANTABUSE-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of possible consequences. He should be warned to avoid alcohol in disguised form, *i.e.* in sauces, vinegars, cough mixtures, and even aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting ANTABUSE.

THE ANTABUSE-ALCOHOL REACTION: ANTABUSE plus alcohol, even small amounts, produces flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of ANTABUSE (disulfiram) and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg. per 100 cc. Symptoms are fully developed at 50 mg. per 100 cc., and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes to several hours in the more severe cases, or as long as there is alcohol in the blood.

DRUG INTERACTIONS: Disulfiram appears to decrease the rate at which certain drugs are metabolized and so may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

Disulfiram should be used with caution in those patients receiving diphenylhydantoin and its congeners, since toxic levels of these antiepileptic agents have been reported during concomitant disulfiram therapy.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status and the disulfiram discontinued if such signs appear.

CONCOMITANT CONDITIONS: Because of the possibility of an accidental ANTABUSE-alcohol reaction, ANTABUSE (disulfiram) should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

USAGE IN PREGNANCY: The safe use of this drug in pregnancy has not been established. Therefore, ANTABUSE should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: It is suggested that every patient under treatment carry an Identification Card, stating that he is receiving ANTABUSE and describing the symptoms most likely to occur as a result of the ANTABUSE-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in emergency. (Cards may be obtained from Ayerst Laboratories upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates have been administered concurrently with ANTABUSE (disulfiram) without untoward effects, but the possibility of initiating a new abuse should be considered.

Base line and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with ANTABUSE therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

ADVERSE REACTIONS: (See Contraindications, Warnings, and Precautions.)

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

There have been reports of polyneuritis and peripheral neuritis, and rare instances of optic neuritis. One case of cholestatic hepatitis has been reported, but its relationship to ANTABUSE has not been unequivocally established.

DOSAGE AND ADMINISTRATION: ANTABUSE (disulfiram) should never be administered until the patient has abstained from alcohol for at least 12 hours.

INITIAL DOSAGE SCHEDULE: In the first phase of treatment, a maximum of 500 mg. daily is given in a single dose for one to two weeks. Although usually taken in the morning, ANTABUSE may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

MAINTENANCE REGIMEN: The average maintenance dose is 250 mg. daily (range, 125 to 500 mg.); it should not exceed 500 mg. daily.

NOTE: Occasional patients, while seemingly on adequate maintenance doses of ANTABUSE, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily ANTABUSE tablets (preferably crushed and well mixed with liquid), it cannot be concluded that ANTABUSE is ineffective.

DURATION OF THERAPY: The daily, uninterrupted administration of ANTABUSE must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

TRIAL WITH ALCOHOL: During early experience with ANTABUSE, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed, and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg. daily, a drink of 15 cc. (½ oz.) of 100 proof whiskey or equivalent is taken slowly. This test dose of alcoholic beverage may be repeated once only so that the total dose does not exceed 30 cc. (1 oz.) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

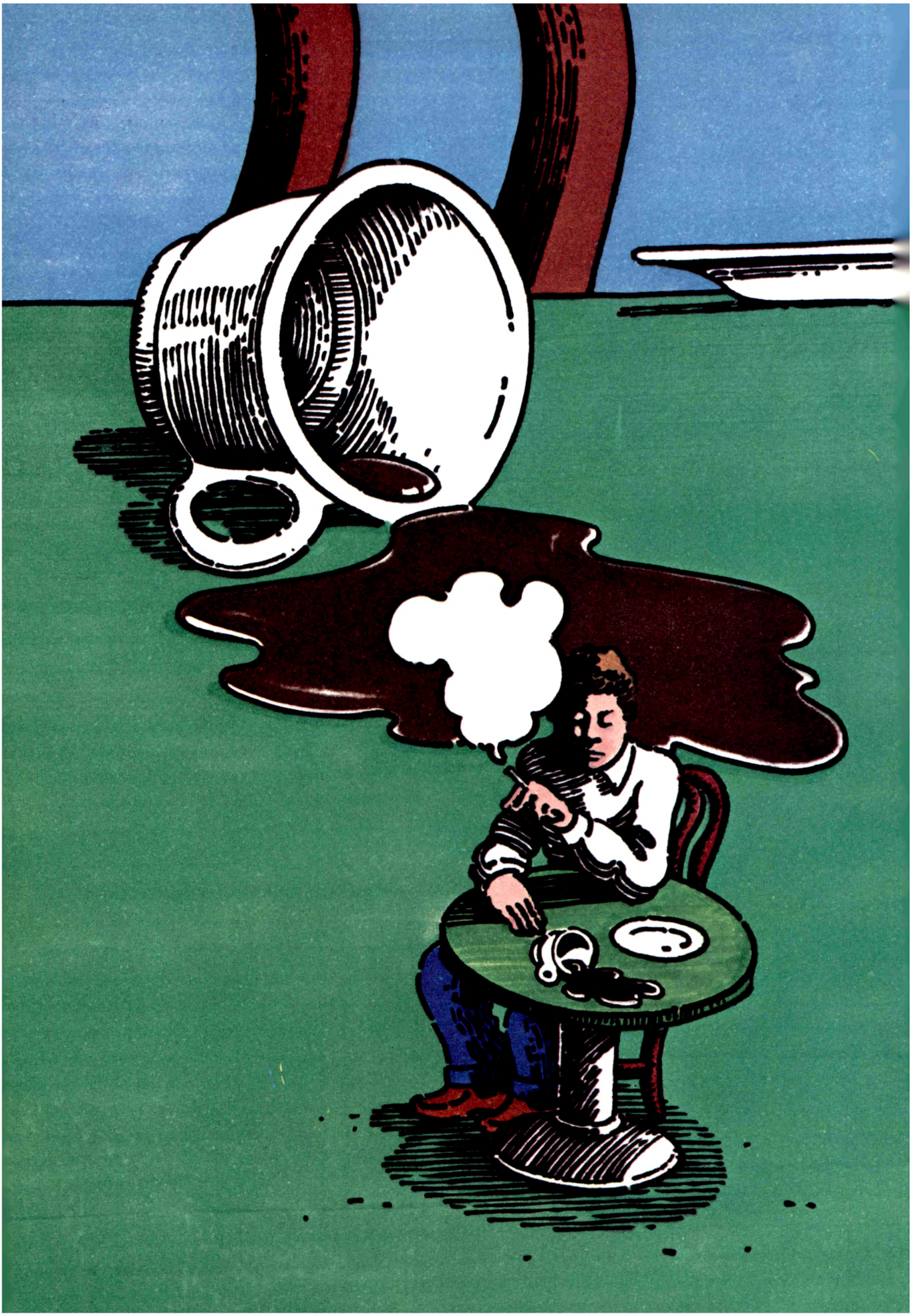
MANAGEMENT OF ANTABUSE (DISULFIRAM)-ALCOHOL REACTION: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95 per cent oxygen and 5 per cent carbon dioxide), vitamin C intravenously in massive doses (1 Gm.), and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored particularly in patients on digitalis since hypokalemia has been reported.

HOW SUPPLIED: No. 809—Each tablet (scored) contains 250 mg. disulfiram, in bottles of 100. No. 810—Each tablet (scored) contains 500 mg. disulfiram, in bottles of 50 and 1,000.

Alcoholism/**ANTABUSE®** (disulfiram)

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

7343



HEL ETI N HIS PERSPECTIVE ON REALITY

With effective management of psychotic symptoms

- Decreases delusions, auditory and visual hallucinations
- Lessens unusual thought content, paranoid ideation
- Allays underlying fear, anxiety and tension
- Controls hostility
- Calms hyperactive behavior
- Reduces emotional withdrawal

Before prescribing, see complete prescribing information including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

Indications
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders. For control of the manifestations of manic-depressive illness (manic phase).

Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

©1967, 1968, 1969 SmithKline Corporation

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg., in bottles of 100; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg., in bottles of 50; Injection, 25 mg./ml.; Syrup, 10 mg./5 ml.; Suppositories, 25 mg. and 100 mg.; Concentrate, 30 mg./ml. and 100 mg./ml.

Smith Kline & French Laboratories
Division of SmithKline Corporation
Philadelphia, Pa. 19101

SK&F

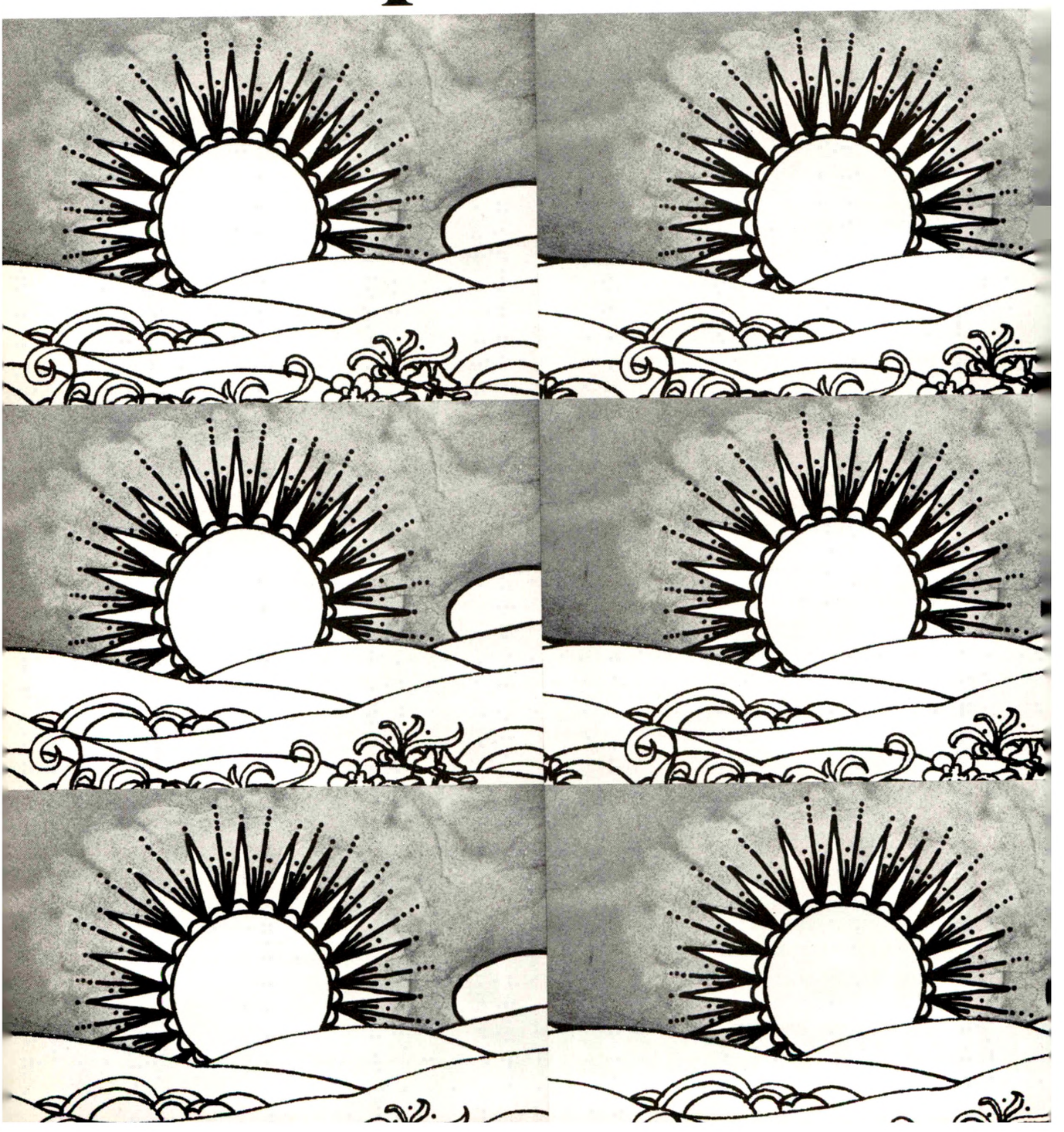
THORAZINE®

brand of

C L P OMAZI E

Tablets:
50 mg. of the HCl

The new-day constant for drug-induced parkinsonism:



ARTANE®
TRIHEXYPHENIDYL HCl

Non-cumulative action makes each day of therapy a new day



That's why ARTANE is ideally suited for the patient on long-term phenothiazine therapy. In economical tablets or SEQUELS Sustained Release Capsules*, it offers you *more* than the rapid reversal of extrapyramidal symptoms.

Usually there is no drug buildup to cause undue toxicity in prolonged therapy. Minimal atropine-like side effects. Accurate dosage titration in adjunctive use. And, to minimize missed doses and anxiety in outpatient therapy— one-dose *all-day* control or prevention with SEQUELS.*

For hospitalized or ambulatory patients, ARTANE has the "constant" they need. Effective *non-cumulative* action.

Tablets—2 mg, 5 mg; Elixir†—2 mg/5 cc or SEQUELS® Sustained Release Capsules—5 mg.

Tablets and Elixir Indications: FDA has evaluated this drug as Effective as an adjunct in the therapy of the indications listed below under SEQUELS.

***INDICATIONS FOR ARTANE SEQUELS:**
Based on a review of this drug in sustained release form by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: Probably effective as an adjunct in the therapy of all forms of parkinsonism (postencephalitic, arteriosclerotic, and idiopathic) and for use in the prevention or control of extrapyramidal disorders due to central nervous system drugs such as reserpine and phenothiazines.

WARNING:
Patients to be treated should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

Precautions: Patients with cardiac, liver or kidney disorders or with hypertension should be maintained under close observation. In long-term therapy, take care to avoid allergic and other untoward reactions. Use with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients require strict dosage regulation. Incipient glaucoma may be precipitated.

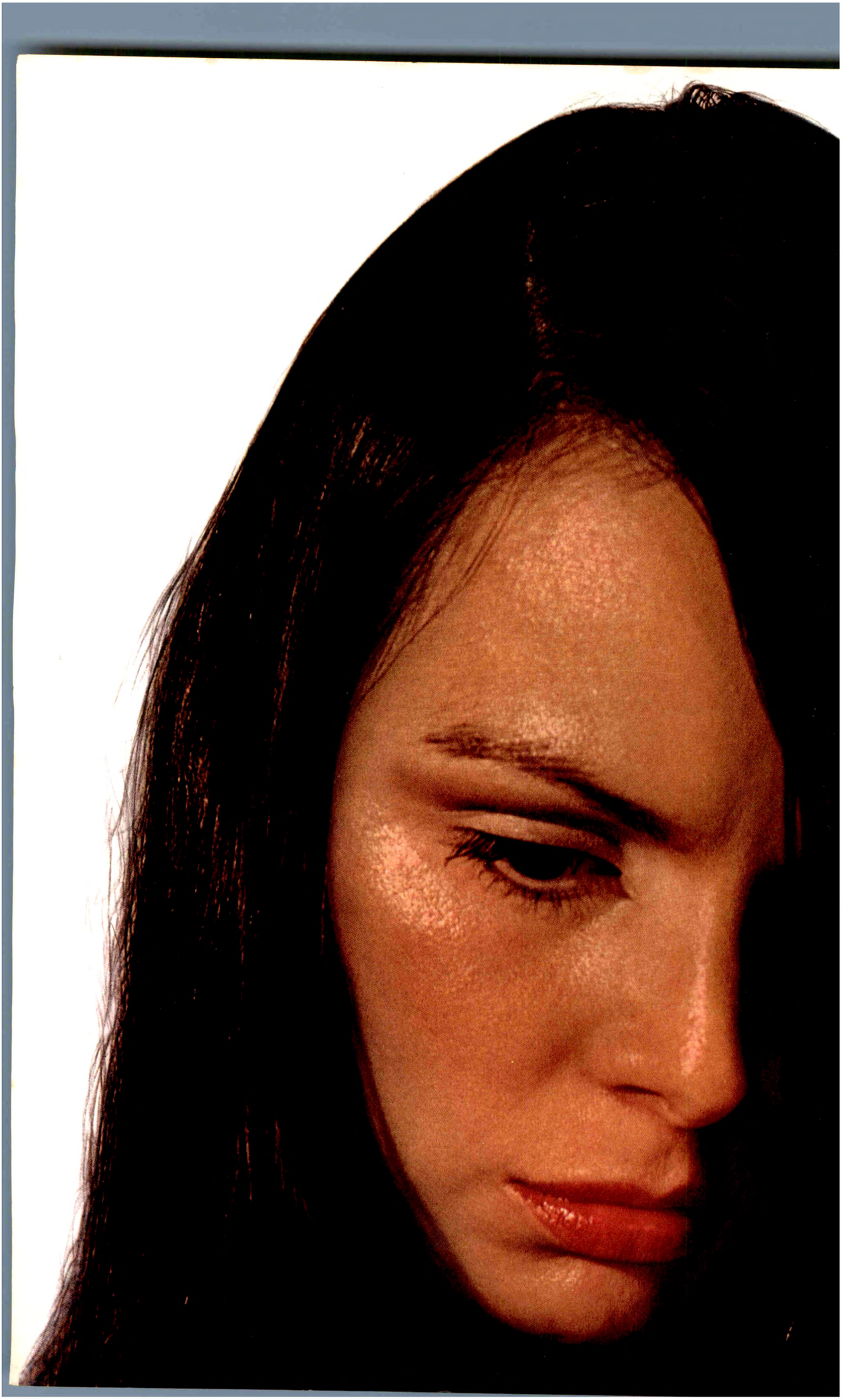
Adverse Reactions: Such effects as dryness of mouth, blurring of vision, dizziness, nausea or nervousness will be experienced by 30 to 50 per cent of patients. (These tend to lessen and can often be controlled by adjusting dosage.) Isolated instances of suppurative parotitis, skin rashes, dilation of the colon, paralytic ileus, delusions, hallucinations and paranoia (1 doubtful case) have been reported. Patients with arteriosclerosis or with a history of idiosyncrasy to drugs may exhibit mental confusion, agitation, disturbed behavior, or nausea and vomiting. If a severe reaction occurs, discontinue drug for a few days, then resume at lower dosage. Psychiatric disturbances can result from overdosage to sustain euphoria. Side effects of any atropine-like drugs include constipation, drowsiness, urinary hesitancy or retention, tachycardia, dilation of the pupil, increased intraocular tension, weakness, vomiting and headache.

†Lime-mint flavored, with 0.08% methylparaben, 0.02% propylparaben, and 5% alcohol as preservatives.

This drug in sustained release form has been evaluated as probably effective. See Brief Summary.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

716-3



too anxious to listen...
too depressed to respond



in mixed anxiety-depression*...

- Consider an agent that combats symptoms of coexisting anxiety and depression
- Consider an agent that acts rapidly
- Consider an agent that contains only *one* active ingredient
- Consider...

Mellaril®
(thioridazine)

TABLETS, 25 mg. thioridazine HCl, U.S.P.

***This drug has been evaluated as probably effective for this indication. See Brief Summary on following page.**

72-556 SANDOZ



too anxious to listen... too depressed to respond

Mellaril®
(thioridazine)

for moderate to severe mixed anxiety-depression*

***Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
Effective: The management of manifestations of psychotic disorders.
"Probably" effective: The relief of symptoms of neurotic depressive reaction; and control of moderate to severe agitation, hyperactivity, or aggressiveness in disturbed children.
"Possibly" effective: Alcohol withdrawal syndrome, intractable pain, psychoneuroses, senility.
Final classification of the less-than-effective indications requires further investigation.

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascul System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single cas described as parotid swelling.

The following reactions have occurred with phenothiazines and should b considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralyt ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact derm titis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thromb cytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Feve laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundic biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electr cardiogram, including prolongation of Q-T interval, lowering and inversion T-wave, and appearance of a wave tentatively identified as a bifid T or a wave have been observed with phenothiazines, including Mellaril (thiorid zine); these appear to be reversible and due to altered repolarization, n myocardial damage. While there is no evidence of a causal relationship b tween these changes and significant disturbance of cardiac rhythm, sever sudden and unexpected deaths apparently due to cardiac arrest have o curred in patients showing characteristic electrocardiographic change while taking the drug. While proposed, periodic electrocardiograms are n regarded as predictive. Hypotension, rarely resulting in cardiac arres *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dyston reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, mu cular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent ar sometimes irreversible tardive dyskinesia, characterized by rhythmical invo untary movements of the tongue, face, mouth, or jaw (e.g., protrusion tongue, puffing of cheeks, puckering of mouth, chewing movements) and some times of extremities may occur on long-term therapy or after discontinuatio of therapy, the risk being greater in elderly patients on high-dose therap especially females; if symptoms appear, discontinue all antipsychoti agents. Syndrome may be masked if treatment is reinstituted, dosage increased, or antipsychotic agent is switched. Fine vermicular movement of tongue may be an early sign, and syndrome may not develop if medica tion is stopped at that time. *Endocrine Disturbances*—Menstrual irregular ties, altered libido, gynecomastia, lactation, weight gain, edema, fals positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical rea tion, including excitement, bizarre dreams, aggravation of psychoses, an toxic confusional states; following long-term treatment, a peculiar skin-ey syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936 72-556

SANDO

THE AMERICAN JOURNAL OF PSYCHIATRY

The Future of Psychoanalytic Therapy

BY JUDD MARMOR, M.D.

The author believes that in the years ahead psychoanalysis will move increasingly toward an open-system biosocial perspective incorporating aspects of field theory, communications and information theory, and general systems theory. There are important implications in this for therapy: while long-term psychoanalytically oriented therapy along classical lines will still be needed for some patients, the analyst should make use of some of the newer techniques (including behavior therapy) that aid in amelioration of symptoms. The author also believes that changes are needed in the training of psychoanalysts; integrating psychoanalytic institutes within academic settings would be especially useful because the services of other behavioral scientists would be readily available to aid in the training of analytic candidates.

CONTRARY TO POPULAR ASSUMPTION, psychoanalysis, either as theory or as technique, has not been a fixed entity at any time in its history. Throughout his life Freud was engaged in a constant effort to bring his theories into more accurate alignment with the scientific models of his time as well as with the observed data of human thought and behavior. Beginning with Ferenczi and Rank and continuing to the present day, individual analysts have been experimenting with modifications in technique. Nonetheless, certain fundamental aspects of Freud's contribution have remained generally accepted by all psychoanalysts.

On the theoretical side, there has been no wavering from the conviction that human behavior is motivated, that our personalities are shaped by the interplay of biological potentials and life experiences, that functional psychiatric disturbances are the result of developmental vicissitudes and contradictory and conflictual inputs and feedbacks, and that early childhood experiences are of special significance in shaping subsequent perceptions and reactions in later life. Regardless of how various theoretical schools of psychoanalysis may differ from one another, I believe that all would subscribe to the foregoing essential elements.

On the therapeutic side, all schools of psychoanalysis aim at basic personality modification by increasing the patient's awareness of his unconscious motivations and conflicts. All place emphasis on the techniques of free association and dream interpretation in the pursuit of this goal, and all share the conviction that the way in which the interpersonal relationship between the analyst and the patient is handled and interpreted is a crucial factor in the therapeutic process. It is worth noting that although adherents of the various psychoanalytic schools of thought differ sharply over what constitutes the best or most "correct" interpretation of the underlying psychodynamics, they all share the assumption that making the correct cognitive interpretation to the patient is a core factor in the therapeutic process.

As the years have passed, however, the classic psychoanalytic model has undergone a number of modifications, and the line of demarcation between psychoanalytic treatment and other forms of dynamic psychotherapy has been blurred. Glover (1) found that this had occurred as early as the late 1930s in his investigation into psychoanalytic practices current in 1939, and Cushing (2), reporting for an official committee of the American Psychoanalytic Association in 1952, stated that after a four-year effort to achieve a consensus the committee had been unable to arrive at any clear-cut criteria for differentiation between psychoanalysis and psychoanalytic psychotherapy. More recently, a study conducted by Tabachnick (3) among Fellows of the American Academy of Psychoanalysis reconfirmed the existence of widely varying patterns of technique among contemporary psychoanalytic practitioners.

INCREASING FLEXIBILITY OF TECHNIQUE

There is no doubt that although there are still those who continue to adhere rigidly to the original therapeutic

Read at the 18th annual meeting of the American Academy of Psychoanalysis, Honolulu, Hawaii, May 5, 1973.

Dr. Marmor is Franz Alexander Professor of Psychiatry, University of Southern California School of Medicine, 2025 Zonal Ave., Los Angeles, Calif. 90033.

technique recommended by Freud, more and more analysts have begun to modify their techniques in a number of ways. Thus they often see their patients two or three times weekly instead of four or five. Many patients are seen sitting up; there is less rigid insistence on the use of the couch. Relatives are interviewed and occasionally even seen conjointly with the patient instead of being strictly excluded, as they were formerly. In contrast to the old dictum that no major life changes were to be permitted for the duration of the analytic process, many analysts not only allow but even encourage their patients to make basic changes in their life patterns when these changes seem rational and constructive. Finally, many psychoanalysts have begun, in general, to feel more free to enter into active communicative exchanges with patients instead of remaining bound to the incognito "neutral mirror" model of relative silence and impassivity.

One important consequence of this trend toward increasing flexibility in technique has been a growing interest in the process of the psychotherapeutic transaction, in contrast to the former preoccupation with its ideational or verbal content. Research into the nature of the psychotherapeutic process (4–6) has begun to make it clear that although cognitive understanding as administered via interpretive "insight" is a valuable adjuvant and facilitator of therapeutic change, it is by no means a sine qua non for such change. Considerable evidence has accumulated to indicate that the psychotherapeutic process is a learning process; what is most relevant to this process, however, is not so much the specific historical correlations between past experiences and current reactions as it is the acquisition of new models of behavior, thinking, and feeling. Moreover, these new models are not always achieved cognitively and consciously; as often as not they are acquired subtly, as a result of overt or covert suggestion, unconscious identification with the therapist, corrective emotional experiences in the interaction with him, and a kind of operant conditioning via implicit or explicit expressions of his approval or disapproval. In this process, the nature and quality of the patient-therapist interaction, the real personalities of both patient and doctor, and the degree of faith, hope, trust, and motivation that the patient brings to the therapeutic situation are of paramount importance in enabling the new learning to take place successfully.

These factors obviously also encompass what psychoanalysts refer to as the transference and countertransference aspects of the psychotherapeutic relationship. In contrast to former concepts that regarded analysis as something that the analyst did to or for the patient, the newer views take cognizance of the active and mutual transaction that takes place between patient and analyst.

While psychoanalytic therapy has been evolving in this way, however, it has begun to face a serious challenge from other psychotherapeutic approaches. A wide variety of behavioral techniques have emerged, all presumptively based on Pavlovian, Hullian, or Skinnerian theories of conditioning and all claiming a high rate of success in ameliorating neurotic symptoms, particularly phobias. These techniques, in contrast to psychoanalysis, tend to eschew cognitive awareness. Their emphasis is strictly on behavioral modification; the subjective problems, feelings, or thoughts of the patient are considered, if not unimportant, at least irrelevant to the psychotherapeutic process.

Another major psychotherapeutic trend, focusing neither on cognitive awareness nor on behavior but rather on feeling states, has been the enormous profusion of so-called Gestalt therapies, encounter groups, marathons (nude or otherwise), and a variety of techniques based on Eastern philosophies and involving transcendental meditation, Zen, Yoga, and the like.

Still another trend leans heavily on advances in technological and communicative techniques as they apply to human behavior. Thus we have witnessed a growing therapeutic use of tape-recorders, movies, videotapes, computers, and electrical stimulating and shocking devices. More recently, biofeedback techniques are being widely explored in an effort to achieve control of both voluntary and autonomic nervous system mechanisms.

Group therapies of many types have been occupying an increasingly important role in the psychotherapeutic spectrum during the past 25 years. Analytic group therapy has been conducted within Freudian, neo-Freudian, and Kleinian orientations; other approaches have invoked psychodrama, sociodrama, transactional gametherapy, and behaviorally oriented role playing or rehearsal.

A number of therapies have leaned heavily on the abreaction-cure theory that Freud initially propounded and later discarded. Among these are Dianetics and its pseudoreligious successor, Scientology, which enables its subjects to recapture presumed intrauterine memories and traumata, and Primal Scream Therapy, which (more modestly!) claims to recover memories only back to the moment of birth. In both of these approaches the recovery of such presumptive memories, together with the release of the associated buried emotions, is supposed to achieve a dramatic cure. The equally dramatic and rapid "cures" of lifelong personality disorders in five or ten sessions with LSD and other psychoactive drugs (amphetamines, barbiturates, carbon dioxide, etc.) that were being widely reported a few years ago were similarly based on the abreaction hypothesis.

UNIQUENESS OF THE PSYCHOANALYTIC APPROACH

Faced with these challenges, the question of what the future holds for psychoanalytic therapy is a valid and realistic one. There are some who argue that psychoanalysis is passé, that its theoretical constructs are outmoded, that it is a dubious therapeutic technique at best, and that its costliness in both time and money can no longer be justified in the face of newer and more effective techniques for symptom amelioration. On the other hand, there are others who continue to insist not only that classical Freudian psychoanalysis is the only basic science of

human behavior, but also that, if it is practiced in accordance with Freud's original precepts, it is still the best therapeutic instrument available for achieving fundamental characterological change.

I have no doubt that the broad concepts underlying the psychoanalytic approach, as I have outlined them, are fundamentally sound and demonstrably valid, and I know of no other technique of psychological investigation as capable of elucidating the subtle complexities of man's subjective inner life. But if psychoanalysis, as a therapeutic method, is defined in terms of a four-to-five-times-a-week, long-term dyadic technique, requiring the couch, focusing heavily on primary process material, and aiming at the promotion of transference regression and the revival of the so-called infantile neurosis, then I, too, would be extremely dubious about its future. I believe that as time goes on this approach will be relegated primarily to investigative and training pursuits and that it will be used less and less frequently for therapeutic purposes.

The essence of the psychoanalytic contribution to therapy, I am deeply convinced, lies not in such technical rigidities but in the basic understanding that psychoanalysis enables one to bring to bear on a variety of therapeutic techniques. Only a sound grasp of psychodynamic principles can enable the psychiatrist to properly evaluate the nature of the patient's underlying conflicts, the strength of his ego-adaptive capacities in relation to his life stresses, and the quality of the therapeutic transaction to which he is most likely to respond favorably. Does the patient need individual or group therapy or both? Should he be seen conjointly with his significant other or not? Will pharmacotherapy facilitate or block his ultimate therapeutic growth? Will it be sufficient therapeutically to reduce or remove the patient's symptoms and/or the stresses in his life, or will it be necessary to aim at basic intrapsychic modifications of personality? Will the patient do better with a man or a woman therapist, with a younger or an older one, with a "cool" or a warm one? Does he require a giving and permissive approach or will he do better with a firm setting of limits?

I do not assume that in our present state of knowledge we psychoanalysts can always give precise answers to all these questions, but I do believe that a sound understanding of psychodynamics makes it possible for us to arrive at more approximately correct answers than any other approach I know of.

I do not underestimate the creative contribution that behavior therapies have made to our armamentarium of therapeutic strategies in the past two decades. I have no doubt that many of their technical contributions will be enduring ones. But in focusing primarily on the "conditioning" aspects of psychopathology and psychotherapy, not only do behavior therapists ignore intervening variables in the genesis of personality disorders, but they also tend to minimize or ignore other significant elements in the psychotherapeutic process, particularly the importance of central cognitive processes and the critical aspects of the interpersonal patient-therapist relationship (7). It is precisely in its appreciation of these subtleties, and in its capacity to explore central cognitive processes, that the psychoanalytic approach brings a unique depth of understanding to the nature of human psychopathology. Only an approach capable of explaining *both* the inner and outer aspects of human behavior offers the hope of giving us the kind of fundamental scientific answers on which rational preventive and therapeutic approaches can be built. It is for this basic reason more than any other that I believe the essence of the psychoanalytic contribution will be an enduring one, even though its ultimate forms will undoubtedly be modified with time.

LIMITATIONS TO DYADIC FREE-ASSOCIATION METHOD

It is my conviction that if psychoanalysis as a therapeutic method is to remain viable, psychoanalysts cannot and must not tie their professional identities to a monolithic model of treatment. Freud developed the classical model primarily as an investigative instrument for the exploration of the unconscious—a purpose for which it still has no equal. But the exploration of the unconscious and optimal psychotherapy are not necessarily synonymous. We all know that toward the end of his life Freud expressed grave doubts about the ultimate therapeutic efficacy of his method of treatment. Moreover, as I have suggested elsewhere (8), there are serious limitations to the purely dyadic free-associational method even with regard to the basic psychoanalytic goal of broadening the patient's field of self-awareness. Not everything that the patient is unaware of in himself necessarily exists within his unconscious because it may never have been registered by his perceptual system; consequently no amount of free association will bring such matters into consciousness.

Also, as Freud himself noted, free association is not always free. It is limited not only by the particular relational framework that exists between patient and therapist, but also by the specific values and expectations of the therapist as communicated by his nonverbal as well as his verbal reactions. The observations of the therapist, too, are limited by this field so that as a consequence certain aspects of the patient's mode of reaction may never come to his attention. Thus it may not only be helpful, but even essential for the achievement of his analytic goal, for the psychoanalyst to broaden his field of observation by bringing in significant others for interviews; for therapeutic interaction with the patient, as in conjoint marital or family therapy; or by placing the patient in a group situation where transference reactions with sibling surrogates, with peers of the same and opposite sex, and with other interpersonal figures can be brought to light.

Otherwise, patients can observe the rules of the free-associational dyadic model beautifully and be regarded as "perfect" analytic patients and yet fail to recognize or bring into the analysis those aspects of their maladaptive personality patterns which are creating interpersonal problems. I have elsewhere (8) referred to a patient

whose compulsive need to dominate a conversation was effectively hidden in the dyadic psychoanalytic model—where she was *supposed* to do all the talking—but became quickly apparent when she was placed in group therapy. Other examples are the patient whose cooperative and compliant relationship with a respected analyst may never bring to light his subtle, unconscious ways of derogating sibling surrogates or the patient whose paranoid distrust of others is so totally rationalized that unless the analyst is able to obtain some outside information along the way its nonvalid basis may never come to light within the positive therapeutic alliance. Let us not forget that the most famous error in the history of psychoanalysis—Freud's belief that his hysterical patients had all been seduced by the parent of the opposite sex—went uncorrected until Freud was able to obtain incontrovertible evidence outside of the analytic situation that the "facts" his patients were reporting to him could not possibly be correct!

There are also stringent limitations in the indications for the strictly dyadic free-associational model. By and large, analysts prefer young, intelligent, articulate adults with reasonably good ego strength and sufficient economic resources to sustain an intensive, long-term therapeutic transaction. Such patients, however, are precisely the ones who are also apt to do well with other forms of treatment. Patients who are "too sick" are often rejected as poor risks for standard psychoanalytic therapy. Yet years ago analysts like Sullivan and Fromm-Reichmann demonstrated that psychoanalytic understanding could be used creatively and constructively in the psychodynamic treatment of schizophrenics and other deeply disturbed patients by modifying the standard technical requirements and working face-to-face in a participant-observer interaction with them. A few years later, Alexander and French and their colleagues at the Chicago Psychoanalytic Institute brilliantly described how psychoanalytic principles and understanding could be applied to shorter-term and less intensive therapeutic techniques with strikingly good results. Finally, the use of psychodynamic group therapies, marital therapies, and family therapies, all within the context of psychoanalytic understanding, have added significantly to our therapeutic potential.

These developments become all the more important when we consider the challenges with which psychoanalysts will be increasingly confronted in our changing socioeconomic milieu and in the face of future health insurance programs. The rapidly burgeoning societal demand for more equitable distribution of mental health care will put increasing pressure on psychiatry to abandon costly long-term, one-to-one psychotherapeutic techniques in favor of more economical short-term or group approaches.

IMPLICATIONS FOR INSURANCE COVERAGE

It may be all very well to argue—as both the American Academy of Psychoanalysis and the American Psychoanalytic Association have done—that long-term psychoanalysis, as a legitimate therapeutic approach, ought not to be excluded from any future national health insurance plan. But on what actuarial basis can we justify a treatment that may include four or five expensive visits per week for an indefinite number of years? There are those who point to renal dialysis as an example of an equally or even more expensive and "interminable" treatment that *has* been included in health insurance programs. This is true. But massive kidney failure is a relatively infrequent disorder, and its cost limits can be estimated more or less accurately. We can argue justifiably and analogously for including the costs of keeping chronic schizophrenics on maintenance programs indefinitely; the indications for such treatment are relatively clear-cut and the incidence of chronic schizophrenia in a population remains fairly constant and can be reasonably estimated from year to year.

Can we define with equal clarity the criteria for standard psychoanalytic treatment? Is there sufficient consensus about the indications for such treatment so that we can say what specific disorder or disorders warrant it? If there were, high cost alone would certainly not be a justification for denying sick patients access to an essential form of treatment. Unfortunately, however, psychoanalysts have generally asserted that almost everyone—at least everyone who is sufficiently articulate, intelligent, and motivated—could benefit from such treatment. But surely it cannot be our intention as psychoanalysts to insist that health insurance plans should pay for the comparatively healthy person who would like the luxury of extending the borders of his self-understanding.

There are some who argue that all of this is irrelevant. There are after all only a limited number of psychoanalysts in our country, and even if all their time were paid for by health insurance plans it would be actuarially feasible to provide this luxury. Perhaps so. But do we psychoanalysts seriously want to insist that we have the right to devote a lifetime of expensive training and not inconsiderable talent to the treatment *at government expense* of a relative handful of people who are not too seriously ill by our own admission (since if they were, they would not be considered suitable for such standard psychoanalytic treatment)? Society cannot be entirely blamed for insisting—if it is to foot the bill—that we make every effort to spread our talents more broadly among those whose needs are greater.

It may be asserted that the refusal to include classical psychoanalysis in health insurance plans will represent a serious loss for psychiatry and will deprive some patients of the opportunity to achieve maximum or optimum therapeutic benefit for their problems. That is a possibility. I suspect, however, that this is more an article of faith than of fact. I know of no hard data to support the conclusion that long-term, four-to-five-times-a-week psychoanalytic treatment produces superior ultimate results in terms of emotional growth and maturation than does long-term, twice-a-week, more flexible psychoanalytically oriented psychotherapy. I do believe, however, that long-term psychoanalytically oriented psycho-

therapy will continue to be needed and can be actuarially and socially justified; I hope that I will not be misunderstood as derogating it or advocating that we relinquish its use. There will always be deeply disturbed patients who have been so traumatized in their crucial early experiences with significant others that, until they have worked through their basic distrust and insecurity in the matrix of a repeatedly tested intimate and empathic psychotherapeutic relationship, they will simply be unable to accept or benefit from other therapeutic approaches. But even such patients may ultimately be able to extend their therapeutic growth by our making other parameters available to them later in their treatment. I am suggesting only that we psychoanalysts be both willing and able to use a flexible rather than a monolithic approach to those who consult us professionally.

NEED TO EXAMINE NEWER TECHNIQUES

Indeed, I would go a step farther and say that as psychoanalysts we should be examining with interest (and not with hostility) all the newer techniques that have been emerging in recent decades. Do they work? If they do, why do they work? And finally, if they work, are any of them capable of being incorporated into our own psychodynamic approach so that we can be of greater assistance to our patients? Feather and Rhoads (9), for example, recently reported on a way of ingeniously combining psychoanalytic concepts with behavior therapy by desensitizing their patients, not to the external anxiety-producing stimuli—as is usually done in behavioral therapies—but rather to the underlying unconscious conflictual drives and impulses from which the symptoms are believed to have been derived. Their reported successes merit further explorations along similar lines.

In short, in justice to our patients we simply cannot continue to ignore the shortcuts to symptom amelioration offered by some behavioral techniques; we must learn to make use of them when indicated. Many patients with sexual dysfunction, for example, deserve a trial with the Masters and Johnson approach to treatment of the couple's interpersonal sexual dynamics before the individual patient is engaged in several years of expensive and intensive exploration of his intrapsychic conflicts and complexes in an effort to psychoanalytically exorcise his or her underlying "castration" anxieties. Similarly, many patients with disabling phobias can now be restored to function in a relatively short time by behaviorally oriented techniques without our having to first put them on the couch for several years.

Such approaches do not preclude the additional use of intensive analytic therapy whenever our psychodynamic evaluation indicates its necessity. The psychoanalyst in such cases is no different from the internist whose patient comes to him, say, with a distressing diarrhea. The physician's first obligation is to do the careful studies that will enable him to diagnose the source of the problem. If the source is a relatively benign one, such as an exogenous food poisoning, simple symptom control by antidiarrheal medication and interdiction of the offending food may be all that is necessary. Should the diagnostic study reveal a more serious underlying disorder, the physician will address himself to that, of course, but at the same time he will do everything he can to control the patient's symptoms and alleviate his suffering.

In psychiatry we have a comparable situation in, for example, the middle-aged woman with a climacteric depression of psychotic proportions. The psychodynamic history may reveal a person who has an underlying restricted, compulsive personality, is sexually inhibited, has low self-esteem, an indifferent husband, and no outside interests, and who decompensated when her only son left home to get married. Few if any of us would consider trying to analyze such a patient without first trying to relieve her disabling depressive symptoms. Yet having done so, most of us would not consider the problem adequately dealt with if we did not try to do something afterward about the patient's underlying psychodynamic and interpersonal problems.

One reason why we psychoanalysts have tended to avoid dealing with neurotic symptoms in the same way has been the myth of symptom substitution. We have generally assumed that if we merely removed a symptom without dealing with its underlying causes a new symptom would inevitably appear in its place. As I have indicated (7), this traditional assumption is based on the closed-system psychodynamic "hydraulic" model that we inherited from Freud. If, however, personality dynamics are more accurately perceived within an open-system frame of reference, such a consequence is not inevitable. Removal of an ego-dystonic symptom may, on the contrary, produce such positive feedback from the environment as to result in major constructive shifts in the original conflictual pattern. Removal of a symptom may also lead to changes in self-perception with resultant ego-syntonic internal feedbacks and heightening of self-esteem, thus also contributing to positive restructuring of internal psychodynamics.

This latter point illustrates the necessity for psychoanalysis to modify some of its theoretical constructs if it is to be able to broaden its therapeutic perspectives. I will not dwell on this point at length because my focus in this essay is primarily on the therapeutic aspects of psychoanalysis. I began this paper, however, by pointing out that change is not alien to psychoanalytic theory, just as it is not alien to therapy. The shift from an id-oriented to an ego-oriented psychology, initiated by Freud himself in 1926 in "The Problem of Anxiety" and carried forward by Wilhelm Reich, Anna Freud, and Heinz Hartmann, the introduction of a more sophisticated cultural orientation by Horney, Fromm, Kardiner, and Erikson, and the development of an interpersonal framework by Sullivan and an adaptational one by Rado have all been steps in this direction. It is now becoming increasingly clear, I believe, that psychoanalysis in the years ahead will be moving more and more toward an open-system biosocial model, incorporating aspects of the field theory of Kurt Lewin, the communications and information theory of Shannon and Weaver, the cybernetic model of Norbert

Wiener, and the general systems theory of Von Bertalanffy. John Bowlby (10) pointed out the way in which our current psychoanalytic theories can be adapted to such a model in his superb volume *Attachment*; more recently, Emanuel Peterfreund (11) attempted to do something similar. I have no doubt that our psychoanalytic theories will eventually be brought into alignment with such current models in the behavioral sciences, which are based on the latest scientific evidence of how the brain (as the organ of what we call "mind") functions. The psychoanalytic theory of mind cannot continue indefinitely to be an abstraction with no connection to the main body of behavioral science theory.

TRAINING THE ANALYST OF THE FUTURE

What I have been saying also has important implications for how we will have to train the psychoanalysts of the future. If psychoanalysis is to continue to be the cutting edge of psychodynamic psychiatry, we can no longer afford to train our candidates primarily by exposing them to the past works of Freud and/or Horney, Sullivan, Rado, etc. Ours must be a living science and should be taught as one. This is not an easy thing to do, because we who are the teachers and who have ourselves been trained in the old tradition are not yet comfortable enough with the new body of knowledge to convey it easily to our students. And yet, despite the difficulties, it is imperative that we make the effort.

I am still of the opinion that integrating our psychoanalytic training institutes within academic settings would facilitate such a changeover, because we would then be able to borrow the talents of other behavioral scientists in the training of our candidates. Moreover, I believe it will be important to go beyond training our candidates only in a dyadic model of therapy. They must be taught how to apply their psychoanalytic understanding to other forms of therapy, particularly group, family, and marital techniques, so that they can more flexibly utilize the therapeutic modality that will most efficiently and effectively modify both the intrapsychic and the interpersonal aspects of the patient's life-system. The professional identity of the psychoanalyst of the future should depend on the theoretical sophistication and depth of understanding that he brings to every aspect of psychiatry not just on his being a technician who has mastered a single therapeutic technique. Such broadening of our professional identity can only increase our scientific stature as psychoanalysts and strengthen our future. To narrow our identity to that of a highly trained technician, on the other hand, will stringently limit our influence and jeopardize that future.

Psychoanalysis, with its deep concern for individual emotional growth, maturation, and self-realization, has been one of the principal guardians of the humanistic tradition in contemporary psychiatry. If we and those whom we are training can continue our own growth and development—in theory, training, and therapy—I am deeply convinced that the light of psychoanalytic understanding will illuminate the field of psychiatry as brightly and prestigiously in the future as it has in the past.

REFERENCES

1. Glover E: The Technique of Psychoanalysis. New York, International Universities Press, 1955, pp 261–350
2. Cushing JGN: Report of committee on evaluation of psychoanalytic therapy. Bulletin of the American Psychoanalytic Association 8:44–50, 1952
3. Tabachnick N: Research committee report on psychoanalytic practice. The Academy 17(1):3–5, 1973
4. Marmor J: Psychoanalytic therapy as an educational process, in Science and Psychoanalysis, vol V. Edited by Masserman J. New York, Grune & Stratton, 1962, pp 286–299
5. Marmor J: Psychoanalytic therapy and theories of learning. Ibid vol VII, 1964, pp 265–279
6. Marmor J: The nature of the psychotherapeutic process, in Psychoneurosis and Schizophrenia. Edited by Usdin GL. Philadelphia JB Lippincott Co, 1966, pp 66–75
7. Marmor J: Dynamic psychotherapy and behavior therapy. Arch Gen Psychiatry 24:22–28, 1971
8. Marmor J: Limitations of free association. Arch Gen Psychiatry 22:160–165, 1970
9. Feather BW, Rhoads JM: Psychodynamic behavior therapy. Arch Gen Psychiatry 26:503–511, 1972
10. Bowlby J: Attachment. New York, Basic Books, 1969
11. Peterfreund E: Information Systems and Psychoanalysis. New York, International Universities Press, 1971

The Concept of Child Advocacy

BY JOHN F. MCDERMOTT, JR., M.D., WILLIAM M. BOLMAN, M.D., ALFRED M. ARENSDORF, M.D., AND RICHARD A. MARKOFF, M.D.

The authors examine the concept of child advocacy in historical perspective, describing its antecedents as reflected in law, education, welfare, and child labor. Although it is not yet realized in practice, child advocacy seems to represent the recognition by society that the developmental needs of its children are so important that they must be ensured as rights to be promoted and protected.

CHILD ADVOCACY, as articulated by the Joint Commission on Mental Health of Children (1), is a catchword for our field in the 1970s. As it is formulated, who could be against it? The intent of the concept is not simply to develop and reorganize a mental health delivery system for children (although this is an enormous task in itself) but also to create a national children's policy that guarantees optimal developmental conditions for all children. It is based on the underlying precept of rights of children, the idea that every child is *entitled* to the basic care and assistance he needs for optimum growth and development. It recognizes that not all parents have the means or capability to provide all the necessary care. So the strengthening of the complementary parental functions of society is required—a role that has been difficult for our governmental systems to carry out. As conceived in proposed legislation there would be a nationwide system of child advocacy at local, state, and federal levels.

Because the word "advocacy" is so broad, it can be subject to various interpretations and definitions. There is a real hazard that it may become simply another inspirational rallying cry for a short-lived evangelism rather than the beginning of a continuing national commitment. It might simply serve as a new lobby bandwagon for child mental health professionals to jump upon, or yet another transient federal grant program embarked upon without adequate consideration of the readiness of society to make it a lasting commitment.

For example, one professional recently stated: "At no previous point in our national history have we found the rhetoric of commitment to children coupled with a professional commitment to the 'whole' child, his family, and his community, extending beyond the territorial interests of separate professional disciplines" (2). But skeptics will point out that historical and social indicators seem against us, that protection of animals antedated protection of children; we still put more money into the protection of animals than of children, and have far more laws protecting business interests than children's interests. Nonetheless, much commentary has appeared in the recent literature on child advocacy as a result of the Joint Commission report (3–7).

This report will examine the concept of advocacy in historical perspective, so that we may look at society's current attitude toward children as a point along a scale of readiness to identify and deal with their needs. In this discussion, we will look particularly for antecedents of child advocacy among broader social attitudes as they are reflected in law, education, welfare, and child labor. If the concept is more than a fad for the 70s, we should be able to find a discernible pattern in history.

HISTORICAL PERSPECTIVES

The notion that childhood is only a recent invention is still startling to many. Of course we acknowledge that Freud called our attention to its special significance for our field only a few decades ago, but that the phenomenon of childhood itself is only 400 years old in Western culture seems incredible. But it is true: the world of fairy stories and special books, games, and toys is a characteristic of modern times. As in some present-day societies, children were regarded as infants until seven or eight years of age and thereafter as adults; initiation rites marked the passage from one to the other. Aries pointed out that, as late as the 12th century, European artists did not even attempt to portray childhood as a reality. Children were painted as miniature adults and wore adult clothing (8).

As for children's "rights," in the Middle Ages these were confined to primogeniture. This social attitude, which was intended to preserve the family structure and avoid competition among siblings, applied a specialness only to the first-born male. By and large, young children were regarded in part as pleasant or petlike animals and in part as defective or incomplete adults (9). The idea of childhood as a graduated developmental continuum simply did not exist, and infants were hurried along into adulthood as fast as possible. Children "just did not count" until they could participate in adult life.

There were a number of reasons for this. Probably the most important were the high mortality rate of children

The authors are with the Department of Psychiatry, University of Hawaii School of Medicine, Leahi Hospital, 3675 Kilauea Ave., Honolulu, Hawaii 96816, where Dr. McDermott is Professor and Chairman, Dr. Bolman is Professor, and Dr. Arensdorf and Dr. Markoff are Assistant Professors.

and the overall economic scarcity. It wasn't worth investing importance in someone who was apt to die before five years of age; one must wait until he not only survived but could earn his own keep. There was good reason for children to adopt adult roles early in order to better prepare them for life—a struggle for survival; because of these economic facts of life, adolescence was unknown.

The special nature of children began to be acknowledged in the 16th century. Children were given different kinds of clothes than their elders and their own toys and games. Thus the notion of childhood was expanded beyond infancy to include school age as a special developmental period. The important role of education has been emphasized in prolonging the period defined as childhood (10). Originally it was prompted by the monks, who recognized the importance of educating the young. In 1524, Martin Luther sent a letter to German municipalities urging upon them the duty of providing schools and upon parents the duty of sending their children to schools (11). Luther should be regarded here as an example of the many individuals whose foresight and leadership led them to recognize the special needs of childhood and to advocate social concern and intervention.

However, social interest remained adultomorphic for many more years; it focused mostly on guiding children's morals and reforming them from their "inborn" evil nature. This religious and moral interest in children has been especially characteristic of Judeo-Christian societies, including the United States. Here the advocate has shifted from the clergyman, who wanted to save the child from his own depravity, to the educator, who wanted to teach him the necessary skills to achieve success. The same objective seemed to pervade one other pioneering advocate function the church had performed for children who had been abandoned—caring for them in orphanages.

Child-Rearing Practices

In a society where physical force was accepted among adults, whippings were used liberally with children and fear was a valued and essential "virtue" to be instilled in a child. Growing up was indeed a battle between the young and the old in which the parents had the power of life or death over their offspring and children had no legal recourse against physical abuse, to say nothing of neglect. In any authoritarian society, children's needs tend to be seen as identical to those of the parent, and thus they are little more than chattels before the law. Of course, adults themselves had little self-determination in those days, as most relationships were authoritarian ones. This may be one reason why parents reacted so violently to independent and self-assertive behavior in children: adults then were very childlike themselves in this area of social maturity. It is interesting to note that the concept of public welfare for unemployed adults also emerged in the 16th century. Social awareness of different categories and degrees of helplessness was perhaps developing.

The long-standing lack of rights for children is well illustrated by the English Poor Law of 1601, which established the *virtue* of child labor and authorized the exploitation of children as miniature and inexpensive workers. This was rationalized as a way to prevent idleness and vagrancy (12), and to keep the relief rolls down. The Industrial Revolution, which will be discussed later as a long-range turning point in the child's favor, in its early days systematically perfected the use and abuse of child labor. And while labor statutes were finally enacted in England and the United States in the 19th century, representing public recognition of the need to protect children from exploitation if society was to advance, the *needs* of children continued to be neglected.

MODERN TIMES

In the 19th and 20th centuries several trends in social attitudes to children became evident. First, medical and public health advances began to reduce infant mortality so that we could consciously determine the size of our families and could afford to become attached to our children, knowing they were likely to survive and return the attachment (13). There has also been an increasing rate of social concern over the needs of children as part of a broad progressive social reform movement. In particular the National Child Labor Committee, founded in 1904, played a prominent role in defending children's rights. This group was a politically effective lobby group with a broad political base of individuals who believed that a healthy and normal childhood was not only the rightful heritage of all children but also essential for the development of socially useful adults.

Underlying the increased social concern for children that characterizes the modern period has been the increase, particularly in the United States, in the productivity of labor and the general wealth of society. These factors permit children to be economically nonproductive for longer and longer periods of time; this, in turn, lays the basis for affectional rather than instrumental or economic attitudes toward children. The growth of organized labor, for example, has been a major factor in the curtailment of child labor.

The White House Conference on Children in 1909 issued the first of many public statements regarding the commitment of this nation to the needs of all its children. President Theodore Roosevelt, an ardent conservationist, supported the creation of a federal bureau to collect information and to disseminate results of scientific research on the care and protection of children. Florence Kelly and Lillian Wald proposed that this "National Commission for Children" perform functions similar to what the U.S. Department of Agriculture did for farm life, that is, to make available and interpret the facts concerning the physical, mental, and moral conditions and prospects of American children. Such views, which closely resemble those of the present day, led to the formation of the U.S. Children's Bureau, which served a major advocate function until its recent reorganization. Later, after the 1930 White House Conference on Children, juvenile courts and child guidance clinics were set up, also presumably in an advocate role; a number of these still exist.

However, a number of critics have pointed out that none of these agencies expanded into comprehensive service networks or stirred up a continuing national commitment to children. Occasionally charismatic figures such as Father Flannigan of Boys Town caught the nation's attention and support, but as with all individual movements, this model failed to develop into a broad-based ongoing commitment. Perhaps the most interesting trend has been that of public education and the school's responsibility for the child. The war between "school and hearth" (14) raged during the last century as well as this; teachers were accused of usurping the rights of the home in areas of discipline and sex education. The state, having replaced the church as the child's advocate, has not been able to decide whether it should be concerned with the child's character, and, if so, in what direction.

DISCUSSION

This incomplete and highly selective historical view leaves many more questions than answers. However, there are some suggestive leads that may merit closer consideration.

First are the two rough dates, 1500 and 1800, that appear as turning points marking three major periods. The first period is that before the 16th century, when the very concept of childhood did not exist. The second period is the three centuries between the 16th and 19th century, when childhood began to acquire an identity and was recognized as having an existence of its own. In this period, childhood acquired sets of attitudes, customs, and behaviors toward children including special clothes and toys as well as recognition of the special needs for support, guidance, and education. Although many of these ideas were religion-oriented and adultocentric, with time they became more scientifically based and child centered. Third is the period from the 19th century to the present, when children have come to be seen as so important to the welfare of the state that social legislation has emerged to protect them from exploitation (as in child labor laws) and to promote their development (as in compulsory public education and the creation of the Children's Bureau). Looked at in the perspective of these historical underpinnings, child advocacy appears to be much more substantial than a passing fad.

If there is any one thing that qualitatively differentiates child advocacy from earlier movements, it is that the goals of child advocacy tend to be phrased in terms of the rights and interests of children themselves rather than in terms of society's self-interest in the reform of child care. This is not to say that earlier concerns with the welfare of children have been totally adult centered. But the steady increase in a child-centered approach seems to have produced, in dialectic fashion, a qualitatively new level of social concern in the current movement for child advocacy.

Although we are not qualified to discuss the relationships between historical and economic forces and changes in social attitudes toward children, our review seems to be a clear reminder that freedom from economic dependence is necessary before a culture can liberalize its attitudes toward children. In 16th-century Europe the economic breakthrough was the large-scale development of commerce; in 19th-century England the event was the Industrial Revolution. Both led to profound social and cultural changes that included new attitudes toward children. If we consider societal values for children relative to other forces, we may be helped to put today's stress on child advocacy in perspective.

A major finding in this historical review is the discrepancy between individual and social attitudes toward children. At least from the time of Jesus, farsighted and charismatic leaders have urged social concern for children and their development; this went on centuries before such ideas were adopted. Yet societies often seem principally concerned with those who make trouble, such as delinquents, or those who elicit sympathy through visible handicap or illness. Predictably this has led to sporadic bursts of interest with either a punitive or a sympathetic approach and little follow-through, resulting in irregular cycles of interest and neglect. Political cycles also contribute to this phenomenon by election-year interest (and perhaps even funding) followed by several years of neglect and failure to follow through.

Of greater importance are social attitudes that reflect the unreal and contradictory conceptualizations of children that have been particularly evident throughout recent history. In particular, Rexford explained the ambivalence of society toward children as the result of their awakening unconscious urges and conflicts in adults that are denied and projected onto the youth of that society (15). Children and youth are therefore eternal reminders of dependency, unfulfilled longings, and the sexual and aggressive problems of mankind. When such attitudes are projected onto children, the usual adult responses are either overidealization and overidentification of childhood, in which society is seen as an adversary, or stern warnings about the need for discipline, control, and moral rectitude, in which the child is seen as an adversary. Redl has used the "Sputnik neurosis" as an example of displacement onto children of concern about our own adequacy vis-à-vis the Russians (16). Other present-day examples in which children become the focus of adult conflicts are school busing (race) and school prayer (religion). The political football of busing in the election primaries of 1972 was a disgraceful example of adult value conflicts being displaced onto children, whose own feelings and reactions were almost totally ignored as the arguments grew louder and louder. The ambivalence described by Rexford is clearly in evidence at the two extreme ends of childhood—infancy and adolescence. The important experiences of infancy are being newly discovered and hotly contested. At the other extreme, adolescence provides a continuing focus of society's own disputes; it is the most recent part of childhood to be "identified" as a special one. Hence it is not surprising that social attitudes are still developing and that conflict over childhood remains the order of the day.

CONCLUSIONS

Despite this, a number of social and cultural currents that are completely unrelated to the problems of projection and ambivalence seem to represent gradual and significant progress toward a general acceptance of children's needs and rights. Although it is not yet possible to sort out their eventual significance, their potential is highly relevant to the continued development of child advocacy.

First, many feel we are in the process of an historical revolution equal to that of the 1500s and 1800s. The terms "post-industrial society," "technocratic revolution," "cybernetic revolution," "information explosion," "spaceship Earth," and many others help to characterize some of the emerging dimensions. Whatever else these terms contain, they imply profound changes in the relationships between a space-aged society and its youth, e.g., the generation gap. The extraordinary demands for adaptation in this period of swift change may soon require matching and supportive societal response toward youth. Besides these qualitative changes in society is the quantitative increase in the numbers of children and youth. Ambivalence and advocacy aside, it is difficult to imagine any nontotalitarian society continuing to ignore the legitimate needs of a group that comprises one-third of its whole! Finally, probably in response to the qualitative and quantitative changes in the state of children and youth in contemporary society, the age of political participation is being changed from 21 to 18 years; in a sense, children are no longer political nonentities. Although it may be argued that this is not a major change, it can also be argued that the late adolescent may vote as a newly arrived emigrant from childhood, with both empathy and advocacy for those who are still prepolitical.

In summary, any of these factors promises to support and extend the concept of child advocacy viewed in historical perspective. Our conclusion, then, is that child advocacy will become a meaningful addition to the store of social and scientific knowledge that becomes history. Although it has not yet been realized in practice, it seems to represent the recognition by society that the developmental needs of its children are of such importance that they must be ensured as rights to be promoted and protected by societal structures. In a sense, the advocacy of the 1970s expresses finally the recognition that the child is not a neurotic symbol or subject for the displacement or projection of adults' hopes and fears; he is neither the property of parents nor a creature of the state.

REFERENCES

1. Joint Commission on Mental Health of Children: Crisis in Child Mental Health—Challenge of the Seventies. New York, Harper & Row, 1971
2. Westman J: A Child Advocacy System for the State of Wisconsin. Madison, University of Wisconsin School of Medicine, Department of Psychiatry, 1971 (processed)
3. Bower E: The Joint Commission report on children: a reaction. Am J Orthopsychiatry 41:793–797, 1971
4. Cohen J: Advocacy and the children's crisis: an invited commentary. Am J Orthopsychiatry 41:807–808, 1971
5. Hersch C: The clinician and the Joint Commission report: a dialogue. J Am Acad Child Psychiatry 10:406–417, 1971
6. Knitzer J: Advocacy and the children's crisis. Am J Orthopsychiatry 41:799–806, 1971
7. Shove M: Whither child advocacy. Am J Orthopsychiatry 41:798, 1971
8. Aries P: Centuries of Childhood. New York, Alfred A Knopf, 1962
9. Hunt D: Parents and Children in History. New York, Basic Books, 1970
10. Vandenberg J: The Changing Nature of Man. New York, WW Norton, 1961
11. Kenward J: Personal communication, March 15, 1971
12. Tattner WL: Crusade for the Children. Chicago, Quadrangle Books, 1970
13. Kadushin A: Child Welfare Services. New York, Macmillan Co, 1967
14. Wishy B: The Child and the Republic. Philadelphia, University of Pennsylvania Press, 1968
15. Rexford E: Children, child psychiatry, and our brave new world. Arch Gen Psychiatry 20:25–37, 1969
16. Redl F: Crisis in the children's field. Am J Orthopsychiatry 32: 759–780, 1962

A Symposium: Should Homosexuality Be in the APA Nomenclature?

ROBERT J. STOLLER, M.D., JUDD MARMOR, M.D., IRVING BIEBER, M.D., RONALD GOLD, CHARLES W. SOCARIDES, M.D., RICHARD GREEN, M.D., AND ROBERT L. SPITZER, M.D.

A session of the annual meeting of the American Psychiatric Association in Honolulu, Hawaii, on May 9, 1973, was devoted to "Should Homosexuality Be in the APA Nomenclature?"[1]

The participants were:

Robert J. Stoller, M.D., Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles.

Judd Marmor, M.D., Franz Alexander Professor of Psychiatry, University of Southern California School of Medicine, Los Angeles.

Irving Bieber, M.D., Clinical Professor of Psychiatry, New York Medical College, New York City.

Ronald Gold, Gay Activists Alliance, New York City.

Charles W. Socarides, M.D., Associate Professor of Psychiatry, Albert Einstein College of Medicine, New York City.

Richard Green, M.D., Associate Professor of Psychiatry in Residence, University of Southern California School of Medicine, Los Angeles.

Their papers are abstracted below. The session was organized and chaired by Robert L. Spitzer, M.D., Director, Evaluation Section, Biometrics Research, New York State Department of Mental Hygiene, 722 West 168 St., New York, N.Y. 10032, and Associate Professor of Clinical Psychiatry, Department of Psychiatry, Columbia University. His paper, which is also abstracted below, was written after the meeting. Reprint requests should be directed to Dr. Spitzer.

Criteria for Psychiatric Diagnosis

BY ROBERT J. STOLLER, M.D.

IS HOMOSEXUALITY a diagnosis? A diagnosis is supposed to be a highly compact explanation. To make a proper diagnosis in any branch of medicine there should be: a syndrome—a constellation of signs and symptoms shared by a group of people, visible to an observer; underlying dynamics (pathogenesis)—pathophysiology in the rest of medicine, neuropathophysiology or psychodynamics in psychiatry; and etiology—those factors from which the dynamics originate. When these exist, one can save time by using shorthand, knowing that a word or two—a label, a diagnosis—communicates to others what we know. Unfortunately, the conditions for which our specialty was developed do not usually fulfill these three criteria.

If one uses the above criteria for considering a condition a diagnosis, homosexuality is not a diagnosis because: 1) there is only a sexual preference (noticeable because it frightens many in our society), not a constellation of signs and symptoms; 2) different people with this sexual preference have different psychodynamics underlying their sexual behavior; and 3) quite different life experiences can cause these dynamics and behavior. There *is* homosexual behavior; it is varied. There is no such *thing* as homosexuality. In that sense it should be removed from the nomenclature.

As regards pathogenesis, probably no one these days, not even among those favoring the diagnosis, believes in a unitary cause for homosexual behavior; that would make it a *thing*. The fine reviews of the literature on etiology by Bieber and associates and Socarides, plus their own findings (1, 2), reinforce the impression that many paths lead to one's preferring members of his own sex. This is true even, and especially, with analytic theories of etiology.

Part of a Natural Realm

However, there is something disreputable in using our feeble method of diagnosis and psychiatrists en masse as the whipping boys for the cruel manner in which homosexuals have been and still are treated. These diagnostic issues are not the real source of homosexuals' mistreatment (although they can be borrowed for such use). At our best, we—since Freud's lead—are partly responsible for the fact that homosexuals can begin fighting back against society. Even though we are inaccurate when we call homosexuality a diagnosis, doing so has signified that the homosexual is part of a natural realm and not a member of the species of damned sinners. If homosexuals hate psychiatrists who would oppress them, let them also concede their debts to those who wish them free. If these niceties are bad for strategy, then let homosexuals—and other minorities—continue to flail us; the cause is honorable although the technique may be crude.

In the search for the multiple causes of homosexual behavior, I believe data can be found demonstrating that for many homosexuals the preferences in object choice and some essential, habitual nonerotic behavior (e.g., the effeminacy of some male homosexuals) were developed

[1] The APA Committee on Nomenclature and Statistics is currently considering this issue. Comments from readers on this question sent to the *Journal* will be forwarded to the committee before its January 1974 meeting.

as the result of trauma and frustration during identity development. Of course, these observations must be understood in the context that I believe they also hold true for most heterosexuals, although the traumas and frustrations are of different sorts and intensities.

Perhaps one can divide humans into two types, heterosexuals and others, as is the custom; if so, we might sort the two in the following idiosyncratic manner (rather as Freud did). I would consider the sexual styles of most humans, including most who prefer homosexual relations, as would-be heterosexual. (Analysts have also shown how heterosexuality may also contain homosexuality.) I believe that the sexual neuroses—the obvious perversions and even most variants of overt heterosexuality, e.g., compulsive promiscuity, use of pornography, preference for prostitutes, adult masturbation—are heterosexual distortions, compromises nonetheless filled with excitement, that allow one to give up certain desires if only others can be salvaged. If it will make the oppressed minorities more comfortable, we can all be given a diagnosis; such pronouncement would certainly not often distort the case. Everyone has his own style and distinctive fantasy content that he daydreams or stages with objects. Everyone is entitled to a category.

But why claim that heterosexuality is mankind's preference? The evidence for this as a biological given is certainly flimsy (although I would guess it is innate in some mild, reversible form). Yet I think that up to the present (not necessarily forever) heterosexuality has been the norm. It is the dominant presence in the ambiance of almost every human in infancy and childhood, because he is created in a family and families are palpably heterosexual (2, pp. 5–6). That sets the standard: heterosexuality is the product of the institution called the family. Then, too, even in childhood we know we are the result of an intimate, highly charged, astonishing, mysterious, unquestionably heterosexual act. So I see perversions (but not all sexual deviations and not all homosexual behaviors) as modifications one must invent in order to preserve some of one's heterosexuality. The form the perversion takes may be far from the extreme of a male preferring a female and vice versa, in which both wholeheartedly enjoy the sexual and loving aspects of their relationship. Yet, while unseen, that ideal may well be buried there in most of us, even if it is manifest in only a few.

A Holding Action

Until the day we know what we are doing, I suggest that—as a holding action—we try the following descriptive syndrome classification system:

A. The personality (character) type, habitual since childhood, e.g., obsessive-compulsive, schizophrenic, hysteric, depressive.
   1. The presenting syndrome, e.g., drug dependence, anxiety neurosis, schizophreniform psychosis.
      a. Subsidiary syndromes also present, e.g., alcoholism; nonpsychotic organic brain syndrome with senile brain disease; psychophysiologic respiratory disorder (asthma).

Sexual preference, e.g., heterosexual, monogamous, with accompanying fantasies of being raped by a stallion; homosexual, with foreskin fetishism; heterosexual, with preference for cadavers; homosexual, with disembodied penises (tearoom promiscuity); heterosexual, voyeurism; homosexual, expressed only in fantasies during intercourse with wife.

Only when diagnoses fail to describe succinctly and accurately should they be removed. Since that is the case for homosexuality, it cannot function as a true diagnosis; remove it. And since that is true for most of the rest of the "diagnoses" of psychiatry, let us scrap the system (although not yet all the labels) and start afresh.

Homosexuality and Cultural Value Systems

BY JUDD MARMOR, M.D.

PROPONENTS of the mental illness label for homosexuality base their arguments on three major themes: 1) that homosexuality is the consequence of "disordered sexual development," 2) that it is a deviation from the biological norm, and 3) that psychodynamic studies of homosexuals always reveal them to be deeply disturbed individuals.

The disordered sexual development theme is based on the finding that a certain type of disturbed parent-child relationship is a background factor in most cases. There seems to be an assumption in this theme that if there is a disturbed parent-child relationship in the background of someone with variant sexual behavior this proves that the disturbed relationship is causally responsible and that the individual with such variant behavior must be mentally ill.

There are a number of fallacies in this argument. First, we know that although most homosexuals show the "typical" family constellation, by no means do all of them. Secondly, not all people who do have such family constellations in their background become homosexual. Third (and most importantly) to call homosexuality the result of disturbed sexual development really says nothing other than that you disapprove of the outcome of that development. *All* personality idiosyncrasies are the result of background developmental differences, and *all* have specific historical antecedents. The concept of illness cannot be extrapolated on the basis of background but must rest on its own merits.

Deviant Behavior not Necessarily Psychopathology

It is my conviction that we do not have the right to label behavior that is deviant from that currently favored by the majority as evidence per se of psychopathology. And, as a matter of fact, we do *not* do so except where we are reflecting our culture's bias toward a particular kind of deviance. In a democratic society we recognize the rights of individuals to hold widely divergent religious or ideational preferences, as long as their holders do not attempt to force their beliefs on others who do not share them. Our attitudes toward divergent sexual preferences,

however, are quite different, obviously because moral values—couched in "medical" and "scientific" rationalizations—are involved.

There are some psychiatrists who would argue that individuals who adhere to unusual life-styles are indeed neurotic and that they suffer from various developmental fixations or arrests that account for their inability to adhere to the behavioral or ideational standards of the majority. Such labeling tends to define normality in terms of behavioral adjustment to cultural conventions rather than in terms of ego strengths and ego-adaptive capacities, and it puts psychiatry clearly in the role of an agent of cultural control rather than of a branch of the healing arts.

Moreover, the relativity of our contemporary sexual mores should not be ignored in any scientific approach to sexual behavior. In a cross-cultural study of 76 societies other than our own, Ford and Beach (3) found that in nearly two-thirds of them homosexual activities were considered normal and socially acceptable, at least for certain members of the community. Nor were all these societies necessarily "primitive" ones. In ancient Greece —a society that we admire and feel indebted to culturally, philosophically, and scientifically—overt homosexual relations between older men and youths was not only considered acceptable but was an institutionalized practice cultivated by heterosexual, healthy, honorable, normal men.

Bisexuality—Our Mammalian Inheritance

The second major argument for the illness viewpoint is that homosexuality, in contrast to other forms of behavioral deviance, is biologically unnatural. Dr. Frank Beach, the eminent biologist, has summarized the evidence on this by pointing out that bisexual behavior has been observed in more than a dozen mammalian species and "undoubtedly occurs in many others not yet studied." He concluded: "Human homosexuality reflects the essential bisexual character of our mammalian inheritance. The extreme modifiability of man's sex life makes possible the conversion of this essential bisexuality into a form of unisexuality with the result that a member of the same sex eventually becomes the only acceptable stimulus to arousal" (4).

Thus, from an objective biological viewpoint there is nothing "unnatural" about homosexual object choice. To illustrate how specious the argument is concerning the supposed biological unnaturalness of homosexuality let us consider some other conditions that are also outside of the presumably customary biological patterns. What about vegetarians? After all, most human beings are "naturally" meat-eaters, but we don't automatically label vegetarians as mentally ill. Or what about celibacy? Do we automatically assume that all people who choose a life of sexual abstinence are mentally ill simply because they do not follow the "natural" biological mating patterns? Obviously, we do not.

The third argument that is often advanced is that any careful study of the personality of homosexuals will show that they are really disturbed individuals. In contrast to Socarides, who holds the view that all homosexuals are practically borderline psychotics, Bieber concedes that many homosexuals can be well-adjusted individuals, but he argues that they still suffer from "pathology."

Happy, Constructive, and Realistic Homosexuals

What *does* constitute the intrinsic "pathology" of a socially well-adjusted homosexual? I submit that in the view of Bieber, Socarides, and others who share their viewpoint, it is primarily that his sexual preference differs from that of the majority of society. I do not deny that there are homosexuals who, just like heterosexuals, suffer from a wide variety of personality disorders and serious mental illnesses, although much of the dis-ease that they suffer from is not intrinsic to their homosexuality but is a consequence of the prejudice and discrimination that they encounter in our society.

But I believe there is now an incontrovertible body of evidence that there are homosexual individuals who, except for their variant object choice, are happy with their lives and have made a constructive and realistic adaptation to being members of a minority group in our society. I consider the kind of evidence that Socarides marshals from his clinical practice as essentially meaningless in this regard. As I have often pointed out, if our judgment about the mental health of heterosexuals were based only on those whom we see in our clinical practices we would have to conclude that all heterosexuals are also mentally ill.

The final absurdity of this is the impossibility of trying to define at what point a person becomes a homosexual who is labeled as having a mental disorder. Some defendants of the illness theory try to justify it by saying that it applies only to obligatory homosexuality. Does this mean that only type 6 homosexuals are mentally ill and all the others are not? Or that types 4, 5, and 6 are ill but not 1, 2, and 3? The whole process of such labeling is unpleasantly reminiscent of the Hitlerian process of trying to determine what fraction of black or Jewish ancestry a person might be permitted to have and still be considered an acceptable member of society with full legal rights.

Surely the time has come for psychiatry to give up the archaic practice of classifying the millions of men and women who accept or prefer homosexual object choices as being, by virtue of that fact alone, mentally ill. The fact that their alternative life-style happens to be out of favor with current cultural conventions must not be a basis in itself for a diagnosis of psychopathology. It is our task as psychiatrists to be healers of the distressed, not watchdogs of our social mores.

Homosexuality—An Adaptive Consequence of Disorder in Psychosexual Development

BY IRVING BIEBER, M.D.

THREE QUESTIONS seem most relevant to the question of

removing the term "homosexuality" from the *Diagnostic and Statistical Manual of Mental Disorders* or changing the current designation:

1. Is homosexuality a normal variant of sexual development and sexual functioning? The long-term study that my colleagues and I reported in 1962 (1), further investigations of colleagues, and the extensive clinical experience of myself and others since then leave no doubt that homosexuality is not merely a variation of normal adult sexuality. Observations on olfaction offer supporting evidence that humans born with normal gonads and genitals are biologically programmed for heterosexual development. From early life, olfaction plays a central role in sexual organization and functioning; it steers the infant toward heterosexual objects and works as an important triggering mechanism in sexual arousal (5, 6). Homosexuality does not occur without antecedent heterosexual development; it appears only *after* sexual responsivity to heterosexual objects has been established. Psychoanalytic evidence of heterosexual responses in homosexuals can almost always be demonstrated.

I have repeatedly emphasized that the dislocations in heterosexual organization of biologically normal children occur as a consequence of pathological family contexts—more specifically, pathologic relationships between parents and child. Typically, mothers of homosexuals are inappropriately close, binding, often seductive, and tend to inhibit boyish aggressiveness. The fathers are overtly or covertly hostile; this is expressed in detachment, streaks of cruelty, or frank brutality. The relationship between the parents is generally poor; often the husband is held in contempt by a wife who prefers her son. The prehomosexual child may be exposed to rejection and hostility from other significant males, such as brothers and peer mates. Defective masculine relationships deprive such a boy of needed masculine figures for identification and modeling that are ultimately sought, in part, in homosexuality. It then becomes a substitutive adaptation, replacing the heterosexuality that is made inadequate or unavailable by a network of induced fears about heterosexual behavior. Within a substitutive adaptation, attempts are made to acquire missing sexual and romantic gratification. Through various homosexual maneuvers and activities, reparative attempts are made to strengthen masculine self-esteem and to alleviate profound feelings of rejection from men. Through homosexuality, reassurance and acceptance are sought from other men. Contrary to popular notions, homosexuality is not an adaptation of choice; it is brought about by fears that inhibit satisfactory heterosexual functioning.

Inherent Psychological Pain

The gay activists and their proponents among some psychiatrists claim that many men are neurotic about their homosexuality only because society is prejudiced. Extinct cultures, such as the ancient Greek, are held up as prejudice-free examples, while cultures and present-day societies where there is no homosexuality are disregarded. The animal evidence has rested heavily on statements by Frank Beach. His position on animal homosexuality has changed, however, and in 1971 he wrote, "I don't know any authenticated instances of males or females in the animal world preferring a homosexual partner, if by homosexuality you mean complete sexual relationships including climax.... It's questionable that mounting in itself can be properly called sexual" (7).

Opponents of my views have accused me and other colleagues with similar ideas of being prejudiced, reactionary, and homophobic. The trouble with such ad hominem attacks is that they do not get to the heart of the matter but serve merely as diversionary methods to discredit without risking an objective engagement with the evidence. As I see it, society at large does not produce a homosexual condition nor can it mitigate the inherent psychological pain. If all discrimination against homosexuals ceased immediately, as indeed it should, I do not think their anxieties, conflicts, loneliness, and frequent depressions would be short-circuited.

2. If homosexuality is not normal, how should it be categorized? In the past century, psychiatry and the allied behavioral sciences have amassed an enormous body of data, although psychiatric diagnostic classification is the weakest part of this extraordinary development. Our present nosology is based on very different categories of criteria. The diagnoses of mania and depression are based on the salient symptom; of schizophrenia, on a constellation or cluster of signs and symptoms; of personality disorders, on psychodynamic formulations; and of sociopathy, on sociologic criteria. Classification of homosexuality has reflected this medley of psychiatric criteria. It is often referred to as "sexual deviation." Literally, deviation is a statistical term denoting movement away from a median or statistical norm. Deviation and pathology are not necessarily related; genius is as deviant as is mental deficiency. In my opinion, the term "sexual deviation" is ambiguous, vague, and not useful as a diagnosis or as a nosologic category.

Homosexuality: Sexual Inadequacy

Masters and Johnson (8) used criteria that qualified as functional and dysfunctional to classify sexual disorders, and they introduced the term "sexual inadequacy." Under this rubric, they included frigidity and sexual impotence. The psychodynamic common denominator of frigidity, impotence, premature ejaculation, and homosexuality consists of a network of fears about being effective in heterosexual activity. I suggest that homosexuality be characterized as a type of sexual inadequacy since most homosexuals (especially those who are exclusively homosexual) cannot function heterosexually.

I think, too, that adaptational concepts are very useful in formulating broader diagnostic contexts. Homosexuality could be classified as an adaptation to inhibited, dislocated heterosexual functioning; this would leave room for an expanded description of the patient's heterosexual difficulties.

3. Does the inclusion of homosexuality in the diagnostic manual make homosexuals "sick," as they claim? Discrimination against homosexuals existed long before modern psychiatric and diagnostic manuals. Psychiatry

particularly psychoanalysis, has contributed significantly toward altering archaic, moralistic, and pseudoscientific concepts. Freud (9) was the first to discard the notion that homosexuality was a degenerative disease. He classified it as a disorder of psychosexual development rather than as sinful and antisocial.

There is no reason to believe that if homosexuality were removed from the diagnostic manual there would be a significant alteration in existing social attitudes. Even if it could be shown that improved social attitudes would eventuate, this would not be reason enough to exclude the term if we agree that homosexuality is not normal and is a treatable condition.

Removal of the term from the manual would be tantamount to an official declaration by APA that homosexuality is normal. Undoubtedly it would be interpreted that way. More importantly, dropping the term would be a serious scientific error. Such an action would also interfere with effective prophylaxis. Prehomosexual boys are easily identifiable and should be treated. Further, young men in conflict about their sexual direction may be discouraged from seeking treatment by those who would reassure them that their homosexual proclivities are normal and that it is only "society," with its outmoded value system, that makes them reject a homosexual preference.

Stop It, You're Making Me Sick!

BY RONALD GOLD

I HAVE come to an unshakable conclusion: the illness theory of homosexuality is a pack of lies, concocted out of the myths of a patriarchal society for a political purpose. Psychiatry—dedicated to making sick people well—has been the cornerstone of a system of oppression that makes gay people sick.

To be viewed as psychologically disturbed in our society is to be thought of and treated as a second-class citizen; being a second-class citizen is not good for mental health. But that isn't the worst thing about a psychiatric diagnosis. The worst thing is that gay people believe it.

Nothing is more likely to create neurotic anxiety than "a lack of feeling of wholeness," and nothing is more likely to alienate you from a major aspect of yourself than to be told incessantly that it's sick.

At 14 years of age I discovered what the "experts" said about the way I love: "infantile sex," "inevitable emotional bankruptcy," "a masquerade of life filled with destruction and self-deceit." So I went to my older sister and she sent me to a psychiatrist. He shot me full of sodium pentothal and scared me out of my wits. It is amazing how I could have kept on believing this nonsense about homosexuality when so little of it had anything to do with my life. But I went willingly to other psychiatrists and learned from them that a part of me I didn't want to give up needed to be excised. I was ready for "psychic annihilation"; I became a heroin addict. This time I was sent to the Menninger Clinic, and there I was convinced that my "cure" must include a change in sexual orientation. So when it was agreed that I was through with treatment, it seemed to me I'd done only half a job. But I soon found that all I needed for another person to love me was to like myself better. I met a young man, and we had a good, happy life for 12 years. When we broke up, our conflicts weren't out of the psychiatric literature. They were just like the tales of heterosexual divorce you read about in *Redbook*.

The man I live with now is a warm, loving, open person. For the past two years we've been going through the joyful process of discovering the full repertory of mutuality—easier for two members of the same sex.

Psychological Growth Through Resisting Oppression

There are advantages to being gay. I learned that in the gay movement. And I learned something else: that I was oppressed and must make the choice to do everything I can to cease being an accomplice in my own oppression. I've had an immense sense of psychological growth through this decision. I've fought through to a sense of myself as a whole person—a good, concerned, loving, fighting-mad homosexual. I'm fighting the psychiatric profession now, but I know that a false adversary situation has been drawn between psychiatry and Gay Liberation. We can save you the trouble of treating some people, and we can be a helpful adjunct for many of your patients by pointing them along the road to self-esteem.

After our meeting with your Committee on Nomenclature and Statistics, its chairman said that "whether a person prefers to have sexual relations with a member of the same or of the opposite sex is in itself not an indicator of mental disorder." But, he added, "What are we to do about the homosexual who comes to us and says he's miserable, that he wants to change?" Such people do need help. But is it their homosexuality that's doing them in? Or is it something that psychiatry has helped to create: irrational fear and hatred of homosexuality? Instead of acceding to requests for brainwashing, what you can help these people realize is that there are many successful, well-adjusted people in various professions (including psychiatry) who are homosexual. You can help them to see that successful sexual adjustment of any kind cannot be achieved in a climate of guilt and fear.

When these patients see themselves as people, not sets of stereotypical patterns, I suspect that most of them (about as many as you get with your current techniques) will go on being gay. Only they'll be happy about it. Perhaps the same percentage you have now will wind up predominantly heterosexual. And many of those who had been exclusively homosexual—many more than you now count as treatment "successes"—will discover a heterosexual component in themselves. We have found that such things happen frequently in the Gay Liberation movement.

I feel better since I've joined Gay Liberation. I work better, I'm happier in love. Would you rather have me the way I am? Or would you suggest another round of therapy? I think you really know that I'm not sick now, that my homosexuality is simply a part of me that in the past I wasn't allowed to accept. And I think you're prepared to

agree that my previous illness was at least in part a direct result of the crimes perpetrated on me by a hostile society. You have been willing accomplices in such crimes. It is now time for you to prevent them. Take the damning label of sickness away from us. Take us out of your nomenclature. Work for repeal of sodomy laws, for civil-rights protections for gay people.

Most important of all, speak out. You've allowed a handful of homophobes to tell the public what you think. It's up to you now to get on the talk shows and write for the weeklies, as they do. You've got to tell the world what you believe—that Gay is Good.

Homosexuality: Findings Derived from 15 Years of Clinical Research

BY CHARLES W. SOCARIDES, M.D.

> I've got to get this homosexual monkey off my back. I just frankly can't live with it. I must either extinguish it, if I can, or maybe by religion extinguish all sex. And the other thing is to be dead. To have anonymous sex with other sick men, I can't make a life out of that. The homosexuals I know think I'm copping out, and if it's not hereditary they feel at least that it's impossible to change. They say to me, "Once homosexuality is established you can't get out or if you do try to get out you'll go nuts." They tell you that you will be isolated and they keep telling you you're a traitor trying to leave the group, turning against your own kind, that you're trying to do something and be something that you're not. They say you're self-indulgent and selfish, feeding your ego in a very selfish kind of way in that you're enjoying your neurosis in trying to get well.

THAT QUOTATION from a patient is why some of us treat homosexuals: because people come to us voluntarily and seek our help. They are in agony over their condition.

The Task Force on Homosexuality appointed by the New York County District Branch of the American Psychiatric Association, of which I was the chairman, unanimously agreed in April 1972 that homosexuality arises experientially from a faulty family constellation. (Some few homosexuals come from an institutional background, but in our opinion they present special problems.) It was our finding that homosexuality represents a disorder of sexual development and does not fall within the range of normal sexual behavior. Further, between one-third and one-half of male homosexuals who seek treatment, including those who had formerly been exclusively homosexual, become exclusively heterosexual as a result of psychoanalytically oriented psychotherapy.

The most extensive comparison study oriented to establishing the etiology of male homosexuality was published in 1962 (1). It is a report on 106 male homosexuals and 100 male heterosexuals, distributed in psychoanalytic treatment with 77 members of the Society of Medical Psychoanalysts.

This study established a continuity and severity of pathological parent-child relationships in the background of all the homosexuals studied to an extent not found in the comparison group. The frequency of a parental combination consisting of a close-binding, overintimate mother and a hostile, detached father statistically differentiated the homosexuals from the heterosexual group at the .01 level of confidence.

The majority of mothers of homosexuals interfered with the development of their sons' peer group relationships, heterosexual development, assertiveness, and decision making; the fathers were demasculinizing. One conclusion of this study was that the son who becomes homosexual is the focal point of this intrafamilial pathology.

Preoedipal Theory of Causation

In 1968 (2), after 15 years of clinical research, I introduced the concept that in all homosexuals there has been an inability to make the progression from the mother-child unity of earliest infancy to individuation. This was called the preoedipal theory of causation. This failure in sexual identity, normally achieved by the age of three, is due to a pathological family constellation in which there is a domineering, psychologically crushing mother who will not allow the child to attain autonomy from her and an absent, weak, or rejecting father who is unable to aid the son to overcome the block in maturation. As a result there exists in (obligatory) homosexuals a partial fixation with the concomitant tendency to regression to the earliest mother-child relationship.

It is my conviction that it is necessary for all human beings to complete the separation-individuation of early childhood (10) in order to establish gender identity. Failure to do so results in a deficit in masculinity for boys, with a corresponding intensification and continuation of the primary feminine identification with the mother; thus begins the course toward homosexual development. It may well be clear now why homosexuality is prevalent, has existed since the beginning of recorded history, and spans all sociocultural levels.

While there was total agreement among members of the task force that the parents, consciously or otherwise, are the primary architects of the homosexual psychic organization, some placed major emphasis on the mother's influence in the preoedipal period, while others stressed the inordinate fears of male aggression coupled with a yearning for male acceptance and affection stemming from the deleterious parental attitudes and behavior. Those who subscribe to preoedipal origin emphasize primitive fears of injury by women.

A sound scientific basis for deciding whether the homosexual suffers from a psychosexual disorder has been handicapped by reports of psychological testing that were offered as proof that there are no discernible differences between homosexuals and heterosexuals insofar as such protocols are concerned (11, 12). Having reviewed these data in detail, we strongly recommend that these tests, dating back to 1957 and 1958, be repeated by other investigators with a much more rigorous methodology than was originally used.

Not a "Sexual Dysfunction"

Scientific knowledge is also damaged when attempts are made to classify homosexuality simply as "sexual dysfunction," a term regularly applied to loss of erection, premature ejaculation, retarded ejaculation, or total impotence. These impairments constitute disturbances of the standard male-female pattern. It is characteristic of the standard or normal sex experience that it take place between a male and a female. It is also characteristic that orgasm produced by intravaginal penetration is fully within the capability of the male partner, and that this coital activity has the potentiality for reproduction. These criteria are basic to elementary human biology and are not subject to change by social or political movements. Individuals unable to achieve sexual release within this standard pattern, with all its possible variations of foreplay, etc. (of which there are an infinite number), turn to modified patterns for orgastic relief, and these constitute sexual deviations. Thus the immutable distinctions between sexual deviations and sexual dysfunctions cannot be semantically blurred without incurring formidable scientific chaos.

As to the contention that in homosexuality there are no clinical symptoms, no course of development, and no treatment, we strongly disagree. There are symptoms and there is a course and there is a treatment—often a very effective treatment. The limitations of space do not allow me to comment on these here beyond observing that in addition to the uncovering techniques of depth therapy, treatment requires educational and retraining measures, interventions, and modifications in the handling of transference, resistance, and regression.

Let us bear in mind that psychiatrists have been in the forefront in helping homosexuals. It was Freud who opened the gates of freedom and humanity to the homosexual. And it was others after him—investigators who dared, who were not afraid of homosexuals, who had no "homophobia" of which we are accused—who could therefore treat homosexuals who want to be treated. I urge that all persecutory laws against the homosexual be abolished at once. It is unthinkable that homosexuals be persecuted for something over which they have no choice. Such laws are a direct contradiction to psychiatric as well as humane values.

Should Heterosexuality Be in the APA Nomenclature?

BY RICHARD GREEN, M.D.

FOUR MAJOR CRITERIA are typically called upon to classify behavior as emotionally disordered. First is gross social dysfunction. Here an individual's behavior is such that to any but the most cynical of observers there is objective evidence that the individual is dysfunctional. The mental functioning of the regressed schizophrenic, the manic, the profoundly depressed, the severely retarded, and the patient with chronic brain syndrome precludes effective social survival.

Second, there exist the less socially obvious emotional limitations. Here inner discord that reduces the efficiency of behavioral functioning is experienced by the individual. Examples include severe anxiety and phobias of various types. Classification of the latter, however, becomes problematic when one considers the relative social consequences of snake phobia, germ phobia, and agoraphobia.

The third criterion of diagnosis is somewhat softer science. This focuses on culturally variant behavior. Using statistical deviance per se as a diagnostic basis evokes problems. Geniuses are deviant. So are the left-handed, vegetarians, pacifists, the celibate, and the esoterically religious. The relationship of idiosyncratic and delusional thinking to cultural accommodation comes into focus when one considers the different view of a religion adhered to by one person, a thousand, or a million. Then too there is the sociopath. His behavior is also deviant and, further, may result in undesirable effects on society. This person may feel no anxiety and not appear grossly dysfunctional. However, his behavior is at odds with external societal values and is labeled as an emotional disorder.

Next, there is a criterion that is scientifically the softest yet. Behavior is judged to be sick or healthy, ordered or disordered, based on a theoretical model of human psychological development. A theory may define specific behavioral phenomena as evidence of disorder. In this regard, classic psychoanalytic theory deems homosexual object choice as psychological immaturity, an arrest of psychosexual development. Castration fear and penis envy are universally posited developmental facts, and resolution of the oedipal crisis is the developmental rite of passage to mature sexuality. The scientific merits of psychoanalytic theory have been debated at length (13).

Heterosexuality as a Disorder

The title of this paper asks the question whether heterosexuality should be in the APA nomenclature. There are in fact some places where heterosexuality and its derivatives are cited. These include pedophilia (presumably this includes children of the opposite sex), exhibitionism (typically the object is a person of the opposite sex), voyeurism (same as the preceding), sadism and masochism (if it is with a partner of the opposite sex), and transvestism (most transvestites are heterosexual).

One additional diagnostic term in our current nomenclature can refer to heterosexuality. This term is under the heading of psychophysiologic genitourinary disorder. Here psychogenic dyspareunia and impotence can be cited, and presumably also nonorgasmia in the female and premature ejaculation in the male.

Are there other places where heterosexual behavior might be considered worthy of diagnosis and classification? Styles of heterosexual conduct do indeed form much of what is dealt with by psychiatrists. Instability in maintaining a love relationship and neurotic uses of sexuality—in which sexuality is used to control others,

as a substitute for other feelings of self-worth, or as a defense against anxiety and depression—constitute a significant bulk of the disorders treated in outpatient psychiatry. Yet there is no specific mention of such ego-dystonic, neurotic uses of heterosexuality in the nomenclature. By contrast, the homosexual is considered to be manifesting a disorder, whether or not he or she is able to maintain a stable interpersonal relationship, feels comfortable about his or her sexuality, and does not utilize it in a self-destructive manner.

Homosexuality as a Disorder

Where in the above gross criteria of mental disorder, other than as a derivative of a theoretical model of personality development, do we place homosexual behavior when it is engaged in by two consenting adults in private? In terms of gross psychologic social functioning the homosexual typically appears no different from his heterosexual counterpart. He or she may hold a responsible occupational and social position. Psychiatrists, other physicians, lawyers, ministers, politicians, authors, etc., may be homosexual. Clearly there is no gross impairment of the kind seen in acute schizophrenia, mania, or organic brain syndromes. With respect to intrapsychic adjustment, the studies that have used comparable samples of nonpatient heterosexual and homosexual subjects typically find no significant differences between the groups on such factors as anxiety and depression (14). With respect to civil issues, homosexual conduct between consenting adults is not illegal in most western European countries, Canada, and some of the United States.

A Proposed New Classification

Can we attain a compatible coalition between those who consider homosexuality a profound mental disorder and those who view it as an alternate life-style beyond the legitimate purview of the medical profession?

The past few years have witnessed an explosion in the research and treatment of various aspects of sexual behavior. Due to the work of Masters and Johnson, considerable professional attention is now being paid to the problems of sexual dysfunction, particularly impotence and premature ejaculation in the male and nonorgasmia in the female. Sexual dysfunction is externally maladaptive and is accompanied by anxiety, depression, and other inner distress.

The more traditional model of emotional disorder considers sexual relationships as dynamic interpersonal phenomena within the scope of ego functioning. Again, compatibility between the phenomena of the homosexually oriented and the heterosexually oriented can be attained. The classification I am proposing here would include the heterosexual or the homosexual who finds it difficult to maintain desired object relationships, who compulsively uses sexuality to ward off anxiety or depression, or whose sexuality typically leads to depression or anxiety. Within this same general category would also be classed those persons who request reorientation or modification of sexual object preference.

The following classification is proposed:

Sexual dysfunction I. This term is applied when physiological dysfunction of psychogenic origin is the primary presenting symptom.

A) Male impotence: 1) with same-sexed partner, 2) with other-sexed partner; B) male premature ejaculation: 1) with partner of same sex, 2) with partner of opposite sex; C) female nonorgasmia: 1) with partner of same sex, 2) with partner of opposite sex.

Sexual dysfunction II. This term is applied when psychogenic distress is the primary presenting symptom. Physiologic dysfunction may or may not be an accompanying factor.

A) Anxiety, depression, and other neurotic reactions secondary to interpersonal aspects of sexuality, not primarily related to physiologic dysfunction: 1) with partner of same sex, 2) with partner of opposite sex; B) dissatisfaction with sexual orientation: 1) dissatisfaction with exclusive or primary homosexual orientation, 2) dissatisfaction with exclusive or primary heterosexual orientation.

The nomenclature would retain exhibitionism, voyeurism, sadism, masochism, pedophilia (and *add* rapism) when such behavior is of a repetitive nature.

With this new classification, psychiatry would have an objective basis for categorizing sexuality that is free of cultural bias, not based on partially accepted theoretic models, not based on the judgment of an external professional agent, but, rather, is patient-activated. Further, it would not stigmatize the individual and would not reinforce legal, religious, and other forms of social discrimination that are a product of the current classification.

A Proposal About Homosexuality and the APA Nomenclature: Homosexuality as an Irregular Form of Sexual Behavior and Sexual Orientation Disturbance as a Psychiatric Disorder

BY ROBERT L. SPITZER, M.D.

CONTROVERSY RAGES as to whether homosexuality should be regarded as a pathological deviation of normal sexual development or as a normal variant of the human potential for sexual response. Recently this controversy has focused on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* second edition *(DSM-II),* in which homosexuality is listed as an official diagnosis in the section on sexual deviations.

The proponents of the view that homosexuality is a normal variant of human sexuality argue for the elimination of any reference to homosexuality in a manual of psychiatric disorders because it is scientifically incorrect, encourages an adversary relationship between psychiatry and the homosexual community, and is misused by some people outside of our profession who wish to deny civil

rights to homosexuals. Those who argue that homosexuality is a pathological disturbance in sexual development assert that to remove homosexuality from the nomenclature would be to give official sanction to this form of deviant sexual development, would be a cowardly act of succumbing to the pressure of a small but vocal band of activist homosexuals who defensively attempt to prove that they are not sick, and would tend to discourage homosexuals from seeking much-needed treatment.

When all of the arguments are carefully examined, a few simple statements can be made with which hardly any major psychiatric opinion would disagree.

1. "Homosexuality" refers to an interest in sexual relations or contact with members of the same sex. Some experts in our field believe that predominant or exclusive homosexuality is pathological; other experts believe it is a normal variant.

2. A significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (other than their homosexuality, if this is considered by itself psychopathology), and are able to function quite effectively. These individuals may never come for treatment, or they may be seen by a psychiatrist because of external pressure (e.g., court referral, family insistence) or because of other problems requiring psychiatric help (e.g., depression, alcoholism).

3. A significant proportion of homosexuals are quite bothered by, in conflict with, or wish to change their sexual orientation. There is debate within our profession as to why this is so. Some argue that it is an inevitable result of the underlying conflicts that cause homosexual behavior in the first place, while others argue that it is derived from a host of social and cultural pressures that have been internalized. Nonetheless, some of these individuals come voluntarily for treatment, either to be able to accept their sexual feelings toward members of the same sex or to increase their capacity for sexual arousal by members of the opposite sex.

4. Modern methods of treatment enable a significant proportion of homosexuals who wish to change their sexual orientation to do so. The exact percentage is controversial and not at all clear. At the same time, homosexuals who are bothered by or in conflict with their sexual feelings but who are either uninterested in changing or unable to change their sexual orientation can be helped to accept themselves as they are and to rid themselves of self-hatred.

What Is a Manual of Mental Disorders?

Decisions about the labeling problem in *DSM-II* require an understanding of the function of a manual of mental disorders. Its purpose, as its name clearly implies, is to list and define mental (psychiatric) disorders. Its purpose is not to list and describe all of the forms of human psychological functioning that are judged by the profession or some members of the profession as less than optimal, nor is its purpose to imply certainty about the nature of conditions when there is not a consensus in the profession.

For a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress or regularly be associated with some generalized impairment in social effectiveness or functioning. With the exception of homosexuality (and perhaps some of the other sexual deviations when they occur in a mild form, such as voyeurism), all of the mental disorders in *DSM-II* fulfill either of these two criteria. (While one may argue that the personality disorders are an exception, on reflection it is clear that it is inappropriate to make a diagnosis of a personality *disorder* merely because of the presence of certain typical personality traits that cause no subjective distress or impairment in social functioning.) Clearly homosexuality per se does not meet the requirements for a psychiatric disorder since, as noted above, many homosexuals are quite satisfied with their sexual orientation and demonstrate no generalized impairment in social effectiveness or functioning.

The only way that homosexuality could therefore be considered a psychiatric disorder would be the criterion of failure to function heterosexually, which is considered optimal in our society and by many members of our profession. However, if failure to function optimally in some important area of life, as judged by either society or the profession, is sufficient to indicate the presence of a psychiatric disorder, then we will have to add to our nomenclature the following conditions: celibacy (failure to function optimally sexually), revolutionary behavior (irrational defiance of social norms), religious fanaticism (dogmatic and rigid adherence to religious doctrine), racism (irrational hatred of certain groups), vegetarianism (unnatural avoidance of carnivorous behavior), and male chauvinism (irrational belief in the inferiority of women).

If homosexuality per se does not meet the criteria for a psychiatric disorder, what is it? Descriptively, it is an irregular form of sexual behavior. Our profession need not now agree on its origin, significance, and value for human happiness when we acknowledge that by itself it does not meet the requirements for a psychiatric disorder.

Sexual Orientation Disturbance

Having suggested that homosexuality per se is not a psychiatric disorder, what about those homosexuals who are troubled by or dissatisfied with their homosexual feelings or behavior? These people have a psychiatric condition by the criterion of subjective distress, whether or not they seek professional help. It is proposed that this condition be given a new diagnostic category, which will replace the current undefined category of homosexuality in subsequent printings of *DSM*, defined as follows: "Sexual orientation disturbance. This is for people whose sexual interests are directed primarily toward people of the same sex and who are bothered by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality per se is a form of irregular sexual behavior and, with other forms of irregular sexual behavior that are not by themselves psychiatric disorders, are not listed in this nomenclature."

What will be the effect of carrying out such a proposal? Homosexual activist groups will no doubt claim that psychiatry has at last recognized that homosexuality is as "normal" as heterosexuality. They will be wrong. In removing homosexuality per se from the nomenclature we are only recognizing that by itself homosexuality does not meet the criteria for being considered a psychiatric disorder. We will in no way be aligning ourselves with any particular viewpoint regarding the etiology or desirability of homosexual behavior.

By creating a new category, "sexual orientation disturbance," we will be applying a label only to those homosexuals who are in some way bothered by their sexual orientation, some of whom may come to us for help. We will no longer insist on a label of sickness for individuals who insist that they are well and who demonstrate no generalized impairment in social effectiveness. We will thus help to answer the charge of some members of our own profession who claim that mental illness is a myth and that by labeling individuals with psychiatric diagnoses we are merely acting as agents of social control. Furthermore, we will be removing one of the justifications for the denial of civil rights to individuals whose only crime is that their sexual orientation is to members of the same sex. In the past, homosexuals have been denied civil rights in many areas of life on the ground that because they suffer from a "mental illness" the burden of proof is on them to demonstrate their competence, reliability, or mental stability. (By linking the removal of homosexuality from the diagnostic nomenclature with an affirmation of the civil rights of homosexuals, no implication is intended justifying the irrational denial of civil rights to individuals who do suffer from true psychiatric disorders.)

This revision in the nomenclature provides the possibility of finding a homosexual to be free of psychiatric disorder, and provides a means to diagnose a mental disorder whose central feature is conflict about homosexual behavior. Therefore, this change should in no way interfere with or embarrass the dedicated psychiatrists and psychoanalysts who have devoted themselves to understanding and treating those homosexuals who have been unhappy with their lot. They, and others in our field, will continue to try to help homosexuals who suffer from what we can now refer to as "sexual orientation disturbance," helping the patient accept or live with his current sexual orientation, or, if he desires, helping him to change it.

REFERENCES

1. Bieber I, Dain HJ, Dince PR, et al: Homosexuality: A Psychoanalytic Study of Male Homosexuals. New York, Basic Books, 1962
2. Socarides CW: The Overt Homosexual. New York, Grune & Stratton, 1968
3. Ford CS, Beach FA: Patterns of Sexual Behavior. New York, Harper & Bros, 1951, pp 125–143
4. Beach FA: Sexual Behavior in Animals and Man, in Harvey Lectures, Series 43:1947–48. Springfield, Ill, Charles C Thomas, 1950, p 276
5. Bieber I: Olfaction in sexual development and adult sexual organization. Am J Psychother 13:851–859, 1959
6. Kalogerakis M: The role of olfaction in sexual development. Psychosom Med 25:420–432, 1963
7. Karlen A: Sexuality and Homosexuality. New York, Norton, 1971, p 309
8. Masters WH, Johnson VE: Human Sexual Inadequacy. Boston, Little, Brown and Co, 1970
9. Freud S: Three essays on the theory of sexuality (1905), in Complete Psychological Works, standard ed, vol 7. Translated and edited by Strachey J. London, Hogarth Press, 1953, pp 125–245
10. Mahler MS: On human symbiosis and the vicissitudes of individuation. J Am Psychoanal Assoc 15:740–763, 1967
11. Hooker E: The adjustment of male homosexuals. Journal of Projective Techniques 21:17–31, 1957
12. Hooker E: Male homosexuality in the Rorschach. Journal of Projective Techniques 22:33–54, 1958
13. Hook S (ed): Psychoanalysis, Scientific Method, and Philosophy. New York, Arone Press, 1959
14. Siegelman M: Adjustment of male homosexuals and heterosexuals. Archives of Sexual Behavior 2:9–26, 1972

Oral Contraceptives, Pyridoxine, and Depression

BY FRANK WINSTON, M.B.B.S.

Taking steroid hormones for the control of ovulation may be associated with depressive mood changes in women who are predisposed to depression. The author postulates that such depression may in some cases be due to inhibition of the synthesis of biogenic amines in the central nervous system as the result of a functional pyridoxine deficiency caused by the estrogen in the oral contraceptives. It is suggested that this depression might be prevented or alleviated by the administration of supplementary vitamin B_6.

INVESTIGATIONS INTO THE EFFECT of oral contraceptives on mood have shown that, while their use may often alleviate premenstrual depression (1–3), a certain number of women will become seriously depressed with continued use (4–12) and that women who have a history of depressive disorder, severe premenstrual weepiness, or depression during pregnancy are those most likely to develop depression when they use oral contraceptives (5, 10, 12). Kutner and Brown (13) have questioned this latter finding.

Herzberg and Coppen (2) found that, although the use of oral contraceptives significantly improved premenstrual depressive symptoms in many of a group of 136 women, nine women stopped taking oral contraceptives because they developed depression and irritability. In a subsequent investigation Herzberg and colleagues (11) found that 6.6 percent of oral contraceptive users were more severely depressed than any member of the control group, but that there was no significant difference between the mean depression scores of the oral contraceptive users and the control group. In a highly critical review of the evidence associating depression with the use of oral contraceptives, Goldzieher and associates (14) found no significant difference in the incidence of nervousness and depression in oral contraceptive users and controls (severity of depression was not measured) and concluded that "the majority of nervousness, depression, and weight gain noted in oral contraceptive users is either coincidental or associated with the psychological impact of taking these agents rather than with any pharmacological effect." Similarly, Leeton and associates (15), in a placebo-controlled study that was based on one menstrual cycle, found no statistical difference between depression scores of oral contraceptive users and those of controls, but suggested that "positive effects on mood may have eliminated negative effects." A further study by Herzberg and colleagues (12) found evidence to support this suggestion, since women who had used the same oral contraceptive for a year had significantly lower mean depression scores than women who had stopped or changed their contraceptive during the same period.

While many investigators concur that depression may be a side effect of the use of oral contraceptives, the cause remains obscure. It has been suggested that depression occurring during oral contraceptive use is a psychological phenomenon (16). Although psychological factors no doubt play a part, the role of hormonal changes induced by oral contraceptives cannot be ignored, particularly since there is a known correlation of psychiatric disorder with the changing hormone levels of the menstrual cycle (17–19).

It has been reported that the more strongly progestogenic contraceptives, which are associated with higher monoamine oxidase (MAO) activity in the endometrium, cause a greater degree of depression (9); this finding led to the suggestion that the depression is related to an increase in brain MAO activity induced by the progestogen (9). Other investigators have failed to confirm this finding (3, 11, 20). In one study (3), statistical evidence was found that contraceptives containing higher doses of progestogen were associated with less severe depression.

There is no evidence that progestogen increases brain MAO. On the contrary, experiments with rats have shown that the injection of progesterone, although it increased endometrial MAO was without effect on other tissues, including brain tissue (21). Further, the amine changes found in rat brain after acute injection with progesterone did not indicate that they were caused by any generalized increase in MAO activity (22). For example, although the level of norepinephrine was lower than normal in the midbrain, it was markedly higher in the cortex and the concentration of 5-hydroxytryptamine (serotonin) was higher in all areas. Herzberg and associates (12) concluded that the susceptibility of the individual woman to developing symptoms is probably of greater importance than the composition of the oral contraceptive. Some possible factors that might determine such individual susceptibility are discussed below.

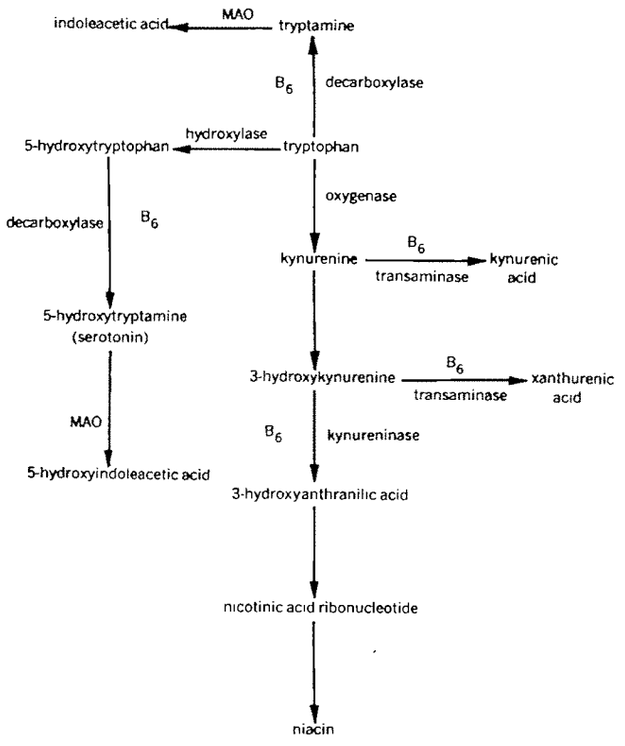
EVIDENCE

According to the biogenic amine hypothesis, the con-

Dr. Winston is in private practice at 313 Price Pl., Madison, Wis. 53705.

The author wishes to thank Dr. Raymond R. Brown, Professor of Clinical Oncology, University of Wisconsin School of Medicine, for his advice and encouragement.

FIGURE 1
*Modified Outline of Tryptophan Metabolism**



*"B_6" indicates that the reaction is dependent on the presence of pyridoxal phosphate.

trol of mood is related in some way to the concentrations in the central nervous system (CNS) of the biogenic amines, particularly serotonin (23, 24), tryptamine (25), and norepinephrine (26). The ratio of the concentrations of these amines is probably more important than the absolute levels of any one of them (27, 28). The concentrations of these amines are regulated by the activity of mitochondrial MAO, their synthesis from dietary amino acids, and other adaptive mechanisms. The evidence is very strong that there is a disturbance of tryptophan metabolism (figure 1) underlying the genesis of affective disorder. Both depressed and manic patients have been shown to have lower levels of 5-hydroxyindoleacetic acid (5-HIAA) in the cerebrospinal fluid than controls, an abnormality that persists after clinical recovery (28). Similarly, patients suffering from endogenous depression excreted significantly higher amounts of kynurenine in the urine than controls, an abnormality that also sometimes continued after recovery (29).

Women taking oral contraceptives show a marked disturbance of tryptophan metabolism along the kynurenine-niacin pathway, with abnormally high urinary excretion of several metabolites, particularly xanthurenic acid and, to a lesser extent, hydroxykynurenine and kynurenine, after receiving a loading dose of tryptophan (30–35). This metabolic disturbance is completely corrected by the administration of a large daily supplement of pyridoxine. A similar disturbance occurs during pregnancy (36, 37) and after the ingestion of cortisone (38). Progestogen given alone does not cause this disturbance (34, 35), so it can be taken to be an estrogenic effect, particularly since estrogen given alone causes the same disturbance (35, 39). Similar disturbances occur transiently during the normal menstrual cycle at the time of ovulation (40, 41) and just before menstruation (41), when estrogen levels are at their highest.

The exact cause of this disturbance has not been defined, but it is thought to be due either to 1) an increase in the formation of kynurenine by the induction of tryptophan oxygenase in the liver, as a result of the increased concentration of plasma cortisol that was induced by the estrogen (42), or 2) interference with certain vitamin B_6-dependent enzyme systems caused by the competition of estrogen conjugates with pyridoxal phosphate for binding sites on the apoenzyme (43). Both mechanisms of course may play a part, but it is clear that estrogen does not act simply by the induction of cortisol since subjects receiving cortisol have been shown to excrete about twice as much xanthurenic acid as controls after a 5 gm. loading dose of tryptophan (38), whereas women taking oral contraceptives excreted an average of 23 times as much xanthurenic acid as controls after a 2 gm. dose of tryptophan (31). This abnormality persists as long as the contraceptives are taken (44) and becomes more marked with time (34), a factor that may be of some importance in evaluating the results of studies of oral contraceptives based on only one menstrual cycle (15).

Lapin and Oxenkrug (45) have postulated that the induction of tryptophan oxygenase by cortisol may result in the shunting of available tryptophan to the kynurenine-niacin pathway and away from the indole pathway, thereby lowering the level of brain serotonin, and that this may be related to the onset of depression. Daily injections of hydrocortisone have been shown to lower the concentrations of serotonin in rat brain; these revert to normal after about five days (46), no doubt due to adaptive mechanisms, one of which is probably the fact that hydrocortisone also induces tryptophan hydroxylase (47). Benkert and Matussek (48) were unable to duplicate this experiment. Since estrogen is known to increase the concentration of circulating cortisol (49) and also to induce tryptophan oxygenase in rats whose ovaries and adrenal glands have been removed (50), it has been suggested that oral contraceptives may lower the concentration of brain serotonin by a similar mechanism (51). Female rats given daily injections of a combination of norethynodrel and mestranol were found to have significantly lower levels of brain serotonin after ten days, but normal levels after 20 days (52). However, the finding that a decrease in the concentration of serotonin of about 50 percent occurs at estrus in rodents (53) suggests a possible source of error in this experiment.

Mason and associates (43) have examined several vitamin B_6-dependent enzyme systems in the tryptophan-

kynurenine-niacin pathway and suggest that estrogen conjugates compete with pyridoxal phosphate for binding sites on the apoenzymes kynureninase and kynurenine transaminase. Since the transaminase is less sensitive to a deficiency of pyridoxal phosphate, xanthurenic acid accumulates; the amount of xanthurenic acid excreted in the urine after the administration of a loading dose of tryptophan is therefore used as an index of pyridoxine deficiency (54). In view of the fact that estrogen conjugates have been shown to inhibit the induction of 5-hydroxytryptophan (5-HTP) decarboxylase in vitro (55), it is not unreasonable to suppose that a similar situation may exist in vivo along the indole pathway; this would reduce the levels of brain serotonin, the synthesis of which is pyridoxine-dependent. Since the enzyme that decarboxylates dopa is also pyridoxine-dependent and is thought to be the same enzyme that decarboxylates 5-HTP (56), catecholamine concentrations may be similarly affected. Four women who were taking oral contraceptives demonstrated a reduction in urinary excretion of catecholamine metabolites (6). In another study, seven women taking oral contraceptives showed alterations in their excretion of catecholamine metabolites, but there was no consistent pattern (8).

It has been shown that up to 25 mg. of pyridoxine daily is required to correct the metabolism of tryptophan along the kynurenine-niacin pathway in women taking oral contraceptives (33, 34, 44). Since the normal diet contains approximately 2 mg. of pyridoxine daily, there is some evidence that oral contraceptives markedly interfere with the proper use of, or increase the need for, pyridoxine.

In view of some of the above considerations, a few women who had developed depression during pregnancy or while taking oral contraceptives were given 50 mg. of pyridoxine daily with apparently favorable results (57, 58). In one case, reduction of the dose to 25 mg. daily resulted in a return of depression that lifted when the dose was increased to 35 mg. Another patient, who required 25 mg. while taking oral contraceptives (58), required 100 mg. during a later pregnancy and 50 mg. daily ten months after delivery, even though she was no longer taking oral contraceptives.

DISCUSSION

The results of a preliminary uncontrolled trial (59) were encouraging enough to indicate the need for placebo-controlled double-blind studies of the effect of pyridoxine on women who complain of the onset or worsening of depression after starting to take oral contraceptives.

The mode of action of pyridoxine is more difficult to determine, since it is impossible to measure changes in the concentrations of amines in the human brain. However, inferences can be drawn from the urinary excretion of indoleamines and catecholamines after the administration of loading doses of tryptophan and L-dopa to depressed women who are taking oral contraceptives with and without pyridoxine. Although this will not necessarily reflect amine activity in the brain, it will be significant if any consistent changes (such as the increased excretion of 5-HTP) are found to correlate with the degree of observed depression. Experiments with 5-HTP labeled with ^{14}C, as developed by Coppen and associates (60), may give information on any possible interference with decarboxylation. Functional pyridoxine deficiency may have no direct effect on the indole pathway, but the serotonin levels might be lowered because of an increase in the amounts of circulating kynurenine and hydroxykynurenine, injections of which have been shown to lower serotonin concentrations in rat brain (61). The concurrent administration of pyridoxine and hydrocortisone does not prevent the reduction of concentrations of serotonin in rat brain (62). This experiment might well be repeated with estrogen injections. However, as has previously been pointed out (51, 62), experiments in rat brain may not be strictly relevant, since the levels of 5-HTP decarboxylase in human brain would appear to be much lower than those in the rat and since the enzyme that controls the rate of synthesis of serotonin in human brain may be 5-HTP decarboxylase rather than tryptophan hydroxylase (63).

Estrogen-induced disturbance of the metabolism of tryptophan is a general effect and cannot in itself be regarded as the cause of depression in women taking oral contraceptives since only a small percentage of women are adversely affected. The development of clinical symptoms probably depends on the failure of the usual regulatory mechanisms. There is evidence that the level of MAO activity is dependent on sex hormones (64), that there is some correlation between peripheral and central MAO activity, and that estrogen may have MAO-inhibiting properties (65). The relief of premenstrual depression in many women who are taking oral contraceptives may be related to this. However, the balance of the effects of estrogen on biogenic amine levels may also depend on the state of enzyme activity at the time of administration and may be dose-related. Depressed women being treated with imipramine appeared to benefit from the addition of 25 μg. of ethinyl estradiol daily, whereas 50 μg. daily produced an adverse effect (66).

Serotonin concentrations in most women might be high enough to allow for some reduction without the appearance of any clinical symptoms, or the concentration might be maintained by a reduction of MAO activity in response to the lowering of the substrate (serotonin). Conceivably the suggested MAO-inhibiting property of estrogen might cancel out any slowing of amine synthesis under normal conditions. Alternatively, the levels of 5-HTP decarboxylase in the brain may normally be high enough to allow for moderate inhibition without any noticeable effect on serotonin levels. However, there may be some women with unusually low concentrations of 5-HTP decarboxylase in the brain who are particularly sensitive to pyridoxine deficiency. The finding that depressed patients have low concentrations of 5-HIAA in their cerebrospinal fluid, not only when ill but long after recovery (28), suggests that their level of amine synthesis re-

mains low, with a corresponding reduction in MAO activity, and that their levels of serotonin may be marginal. In such a patient the further inhibition of amine synthesis, e.g., as a result of taking oral contraceptives, may precipitate the appearance of clinical symptoms, since further regulation may not be possible. It is in this situation that supplementary pyridoxine may be able to prevent any adverse effects on mood.

However, in view of the many decarboxylase and transaminase reactions that are pyridoxine-dependent, it is unlikely that functional pyridoxine deficiency would manifest itself in only one clinical symptom, i.e., depression, and consideration must be given to the possibility that it contributes to other side effects of oral contraceptives (34, 67).

The administration of pyridoxine (68) has been shown to improve the impaired glucose tolerance curve frequently observed in women taking oral contraceptives (69), possibly by reducing the formation of excess xanthurenic acid, which has been shown to combine with circulating insulin to form a complex that reduces its effect on the blood glucose level (70).

Clinical experience (71) suggests that women with severe premenstrual depression and a history of previous depressive disorder and/or depression during pregnancy and whose symptoms become worse after they begin to use oral contraceptives are those who are most likely to respond to pyridoxine. This would appear to be the same group of women Herzberg and associates (12) described as those most likely to become depressed while using oral contraceptives. Of 250 such women, 220 appeared to show a good response to pyridoxine under uncontrolled conditions; many of these women continued to take pyridoxine after discontinuing the use of oral contraceptives (71). This suggests that a number of women with premenstrual depression that is not associated with the use of oral contraceptives will be found to be pyridoxine responders. However, women in this group form a very small percentage of the total number of women with premenstrual depression. In a controlled study of the effect of pyridoxine on premenstrual depression that was not associated with the use of oral contraceptives (and that excluded those women whose symptoms were severe enough to require psychoactive medication), only one out of 13 women showed significant improvement and one became worse (72, 73). This result lends support to the view that premenstrual depression in normal women is not significantly associated with impaired amine synthesis but that this may be the case with women who respond to pyridoxine.

In a recent double-blind crossover trial of the effect of pyridoxine on depression that *was* associated with the use of oral contraceptives, by women who had no previous history of psychiatric illness, 11 of 22 women showed biochemical evidence of absolute (as opposed to relative) vitamin B_6 deficiency.[1] The administration of supplementary pyridoxine significantly relieved the depressive symptoms of the 11 members of this subgroup but had no effect on the remainder (74).

[1] The term "absolute vitamin B_6 deficiency" is used in this context to imply the existence of a subnormal level of pyridoxal phosphate in tissues.

REFERENCES

1. Goldzieher JW, Moses LE, Ellis LT: Study of norethindrone in contraception. JAMA 180:359–361, 1962
2. Herzberg BN, Coppen A: Changes in psychological symptoms in women taking oral contraceptives. Br J Psychiatry 116:161–164, 1970
3. Kutner JS, Brown WL: Types of oral contraceptives, depression, and premenstrual symptoms. J Nerv Ment Dis 155:153–162, 1972
4. Daly RJ, Kane FJ Jr, Ewing JA: Psychosis associated with the use of a sequential oral contraceptive. Lancet 2:444–445, 1967
5. Lewis A, Hoghughi M: An evaluation of depression as a side effect of oral contraceptives. Br J Psychiatry 115:697–701, 1969
6. Marcotte DB, Kane FJ Jr, Obrist P, et al: Psychophysiologic changes accompanying oral contraceptive use. Br J Psychiatry 116:165–167, 1970
7. Grounds D, Davies B, Mowbray R: The contraceptive pill, side effects and personality: report of a controlled double-blind trial. Br J Psychiatry 116:169–172, 1970
8. Kane FJ Jr, Lipton MA, Krall AR, et al: Psychoendocrine study of oral contraceptive agents. Am J Psychiatry 127:443–450, 1970
9. Grant ECG, Pryse-Davies J: Effect of oral contraceptives on depressive mood changes and on endometrial monoamine oxidase and phosphatases. Br Med J 3:777–780, 1968
10. Nilsson A, Jacobson L, Ingemanson CA: Side effects of an oral contraceptive with particular attention to mental symptoms and sexual adaptation. Acta Psychiatr Scand 44 (suppl 203):259–260, 1968
11. Herzberg BN, Johnson AL, Brown S: Depressive symptoms and oral contraceptives. Br Med J 4:142–145, 1970
12. Herzberg BN, Draper KC, Johnson AL, et al: Oral contraceptives, depression, and libido. Br Med J 3:495–500, 1971
13. Kutner JS, Brown WL: History of depression as a risk factor for depression with oral contraceptives and discontinuance. J Nerv Ment Dis 155:163–169, 1972
14. Goldzieher JW, Moses LE, Averkin E, et al: Nervousness and depression attributed to oral contraceptives: a double-blind placebo-controlled study. Am J Obstet Gynecol 111:1013–1020, 1971
15. Leeton J, Leinkram C, Stiglitz J: The relationship of oral contraception to depression. Aust NZ J Obstet Gynaecol 11:237–240, 1971
16. Fortin JN, Wittkower ED, Paiement J, et al: Side effects of oral contraceptive medication: a psychosomatic problem. Can Psychiatr Assoc J 17:3–10, 1972
17. Dalton K: Menstruation and acute psychiatric illnesses. Br Med J 1:148–149, 1959
18. Janowsky DS, Gorney R, Castelnuovo-Tedesco P, et al: Premenstrual-menstrual increases in psychiatric hospital admission rates. Am J Obstet Gynecol 103:189–191, 1969
19. Janowsky DS, Gorney R, Mandell AJ: The menstrual cycle: psychiatric and ovarian-adrenocortical hormone correlates—case study and literature review. Arch Gen Psychiatry 17:459–469, 1967
20. West J: Mood and the pill. Br Med J 4:187–188, 1968
21. Southgate J, Collins GGS, Pryse-Davies J, et al: Effect of contraceptive steroids on monoamine oxidase activity. J Clin Pathol 23 (suppl 3):43–48, 1970
22. Tonge SR, Greengrass PM: The acute effects of oestrogen and progesterone on the monoamine levels of the brain of ovariectomised rats. Psychopharmacologia 21:374–381, 1971
23. Coppen A: The biochemistry of affective disorders. Br J Psychiatry 113:1237–1264, 1967
24. Curzon G: Tryptophan pyrrolase—a biochemical factor in depressive illness. Br J Psychiatry 115:1367–1374, 1969
25. Dewhurst WG: New theory of cerebral amine function and its clinical application. Nature 218:1130–1133, 1968

26. Schildkraut JJ: The catecholamine hypothesis of affective disorders: a review of supporting evidence. Am J Psychiatry 122:509–522, 1965
27. Kety S: Brain amines and affective disorders, in Brain Chemistry and Mental Disease. Edited by Ho BT, McIsaac WM. New York, Plenum Press, 1971, pp 237–244
28. Coppen A, Prange AJ Jr, Whybrow PC, et al: Abnormalities of indoleamines in affective disorders. Arch Gen Psychiatry 26:474–478, 1972
29. Curzon G, Bridges PK: Tryptophan metabolism in depression. J Neurol Neurosurg Psychiatry 33:698–704, 1970
30. Rose DP: Excretion of xanthurenic acid in the urine of women taking progestogen-oestrogen preparations. Nature 210:196–197, 1966
31. Price JM, Thornton MJ, Mueller LM: Tryptophan metabolism in women using steroid hormones for ovulation control. Am J Clin Nutr 20:452–456, 1967
32. Rose DP, Braidman IP: Excretion of tryptophan metabolites as affected by pregnancy, contraceptive steroids, and steroid hormones. Am J Clin Nutr 24:673–683, 1971
33. Luhby AL, Brin M, Gordon M, et al: Vitamin B_6 metabolism in users of oral contraceptive agents, I: abnormal urinary xanthurenic acid excretion and its correction by pyridoxine. Am J Clin Nutr 24:684–693, 1971
34. Rose DP, Adams PW: Oral contraceptives and tryptophan metabolism: effects of oestrogen in low dose combined with a progestogen and of a low dose progestogen (megastrol acetate) given alone. J Clin Pathol 25:252–258, 1972
35. Brown RR, Rose DP, Price JM, et al: Tryptophan metabolism as affected by anovulatory agents. Ann NY Acad Sci 166:44–56, 1969
36. Sprince I, Lowy HRS, Folsome CE, et al: Studies on the urinary excretion of "xanthurenic acid" during normal and abnormal pregnancy: a survey of the excretion of "xanthurenic acid" in normal nonpregnant, normal pregnant, pre-eclamptic, and eclamptic women. Am J Obstet Gynecol 62:84–92, 1951
37. Vandelli I: The use of vitamin B_6 (pyridoxine) for suppressing the elimination of xanthurenic acid in pregnant and non-pregnant women following the oral intake of a measured quantity of tryptophan. Acta Vitaminologica 5:55–61, 1951
38. Rose DP, McGinty F: The influence of adrenocortical hormones and vitamins upon tryptophan metabolism in man. Clin Sci 35:1–9, 1968
39. Rose DP: The influence of oestrogens on tryptophan metabolism in man. Clin Sci 31:265–272, 1966
40. Rose DP: The influence of sex, age, and breast cancer on tryptophan metabolism. Clin Chim Acta 18:221–225, 1967
41. Brown RR, Thornton MJ, Price JM: The effect of vitamin supplementation on the urinary excretion of tryptophan metabolites by pregnant women. J Clin Invest 40:617–623, 1961
42. Rose DP: Oral contraceptives and depression. Lancet 2:321, 1969
43. Mason M, Ford J, Wu HLC: Effects of steroid and nonsteroid metabolites on enzyme conformation and pyridoxal phosphate binding. Ann NY Acad Sci 166:170–183, 1969
44. Luhby AL, Davis P, Murphy M, et al: Pyridoxine and oral contraceptives. Lancet 2:1083, 1970
45. Lapin LP, Oxenkrug GF: Intensification of the central serotoninergic processes as a possible determinant of the thymoleptic effect. Lancet 1:132–136, 1969
46. Curzon G, Green AR: Effect of hydrocortisone on rat brain 5-hydroxytryptamine. Life Sci 7:657–663, 1968
47. Azmitia EC Jr, McEwen B: Corticosterone regulation of tryptophan hydroxylase in midbrain of rat. Science 166:1274–1276, 1969
48. Benkert O, Matussek N: Influence of hydrocortisone and glucagon on liver tyrosine transaminase and on brain tyrosine, norepinephrine, and serotonin. Nature 228:73–75, 1970
49. Burke CW: The effect of oral contraceptives on cortisol metabolism. J Clin Pathol 23(suppl 3):11–18, 1970
50. Brin M: Abnormal tryptophan metabolism in pregnancy and with the oral contraceptive pill, I: specific effects of an oral estrogenic contraceptive steroid on the tryptophan oxygenase and two aminotransferase activities in livers of ovariectomized, adrenalectomized rats. Am J Clin Nutr 24:699–703, 1972
51. Rose DP: Aspects of tryptophan metabolism in health and disease: a review. J Clin Pathol 25:17–25, 1972
52. Nistico G, Preziosi P: Contraceptives, brain serotonin and liver tryptophan pyrrolase. Lancet 2:213, 1970
53. Greengrass PM, Tonge SR: Changes in brain monoamine concentrations during oestrous cycle in mouse: possible pharmacological implications. J Pharm Pharmacol 23:897–898, 1971
54. Coon WW, Nagler E: The tryptophan load as a test for pyridoxine deficiency in hospitalized patients. Ann NY Acad Sci 166:30–43, 1969
55. Mason M, Schirch L: Inhibition of B_6 enzymes by free and conjugated estrogens. Fed Proc 20:200, 1961
56. Lovenberg W, Weissbach H, Udenfriend S: Aromatic l-amino acid decarboxylase. J Biol Chem 237:89–93, 1962
57. Winston F: Oral contraceptives and depression. Lancet 2:1209, 1969
58. Winston F: Oral contraceptives and depression. Lancet 2:377, 1969
59. Baumblatt MJ, Winston F: Pyridoxine and the pill. Lancet 1:833, 1970
60. Coppen A, Shaw DM, Malleson A: Changes in 5-hydoxytryptophan metabolism in depression. Br J Psychiatry 111:105–107, 1965
61. Green AR, Curzon G: The effect of tryptophan metabolites on brain 5-hydroxytryptamine metabolism. Biochem Pharmacol 19:2061–2068, 1970
62. Green AR, Joseph MH, Curzon G: Oral contraceptives, depression, and amino acid metabolism. Lancet 1:1288, 1970
63. Robins E, Robins JM, Croninger AB, et al: The low level of 5-hydroxytryptophan decarboxylase in human brain. Biochem Med 1:240–251, 1967
64. Tryding N, Tufvesson G, Nilsson S: Ageing, monoamines, and monoamine-oxidase levels. Lancet 1:489, 1972
65. Klaiber EL, Broverman DM, Vogel W, et al: Effects of estrogen therapy on plasma MAO activity and EEG driving responses of depressed women. Am J Psychiatry 128:1492–1498, 1972
66. Prange AJ Jr, Wilson IC, Alltop LB: The effect of estrogen on imipramine response in depressed women. JAMA 219:143–144, 1972
67. Price SA, Toseland PA: Oral contraceptives and depression. Lancet 2:158–159, 1969
68. Spellacy WN, Buhi WC, Birk SA: The effects of vitamin B_6 on carbohydrate metabolism in women taking steroid contraceptives: preliminary report. Contraception 6:265–273, 1972
69. Wynn V, Doar JWH: Some effects of oral contraceptives on carbohydrate metabolism. Lancet 2:761–766, 1969
70. Kotake Y, Murakami E: A possible diabetogenic role for tryptophan metabolites and effects of xanthurenic acid on insulin. Am J Clin Nutr 24:826–829, 1971
71. Baumblatt MJ: Personal communication, Dec 7, 1972
72. Stokes J, Mendels J: Controlled trial of pyridoxine for premenstrual mood changes. Read at the Fifth World Congress of Psychiatry, Mexico City, Mexico, Nov 28–Dec 4, 1971
73. Stokes J, Mendels J: Pyridoxine and premenstrual tension. Lancet 1:1177–1178, 1972
74. Adams PW, Rose DP, Folkard J, et al: Effect of pyridoxine hydrochloride (vitamin B_6) upon depression associated with oral contraception. Lancet 1:897–904, 1973

Subjects' Recent Life Changes and Coronary Heart Disease in Finland

BY CDR. RICHARD H. RAHE, MC, USNR, LINDA BENNETT, MATTI ROMO, M.D., PENTTI SILTANEN, M.D., AND CAPT. RANSOM J. ARTHUR, MC, USN

Data on recent life changes were gathered for 279 survivors of myocardial infarction and 226 victims of sudden coronary death in Helsinki, Finland. Subjects in both groups experienced a significant increase in recent life changes during the six months prior to infarction or death compared with the same six-month period one year earlier. Subjects were compared according to whether they had shown marked, moderate, or no increase in recent life changes. The authors point out the usefulness of including data on precipitating factors in prospective studies of coronary heart disease along with data on such physical risk factors as serum cholesterol levels and systolic blood pressure.

MORE THAN TWO DECADES of epidemiologic research, both in the United States and in Europe, have resulted in the identification of a number of "risk factors" that seemingly predispose certain people to the development of coronary heart disease (1–3). Among these factors are serum cholesterol levels, blood pressure, degree of body fat, and cigarette smoking, as well as selected psychological traits concerning competitiveness, a "driven" quality, and a feeling of the urgency of time. With the possible exception of cigarette smoking, these factors are not considered to be precipitants of coronary crises such as myocardial infarction or sudden coronary death (4).

Recent changes in subjects' lives have shown promise as possible precipitating factors in a number of disease entities, including coronary heart disease (5–8). Survivors of myocardial infarction have reported significantly more life changes over the final six months before the infarction than during comparable intervals of time a year or two earlier. In addition, reports by the spouses of the victims of sudden coronary death have noted significant increases in recent life changes during the six-month period immediately before death compared with corresponding six-month periods one or two years earlier. Since these previous investigations were carried out with relatively small samples, the present study was designed as an attempt to replicate these previous findings, using a sample of over 500 persons. Finland proved to be the ideal country for such a study for two reasons: 1) the cooperation given to medical examiners by Scandinavians is excellent, and 2) Finland has been shown to have rates of incidence and prevalence of coronary heart disease that are among the world's highest (9).

Cdr. Rahe, Ms. Bennett, and Capt. Arthur are with the U.S. Navy Medical Neuropsychiatric Research Unit, San Diego, Calif. 92152, where Cdr. Rahe is Head of the Biochemical Correlates Division, Ms. Bennett is Research Associate, and Capt. Arthur is Commanding Officer. Dr. Romo is Principal Investigator of the Ischemic Heart Disease Register and Dr. Siltanen is Medical Director of the Finnish Heart Association, Helsinki, Finland.

This work was supported in part by the Bureau of Medicine and Surgery, Department of the Navy, under Research Work Unit MR011.01-6110 1N, and in part by the Signe and Ane Gyllenberg Foundation, Helsinki, Finland.

The authors wish to thank Heikki and Seija Arajärvi, who coordinated the Finnish translation of the Schedule of Recent Experience questionnaire; Kyllikki Miettinen, Tuula Lilnanto, and Sirkka Laakso, the nurse-interviewers; and Marita Puranen, who provided secretarial assistance.

The opinions expressed herein are those of the authors and do not necessarily reflect the views or endorsement of the Department of the Navy.

METHOD

The Finnish Heart Association, in cooperation with the World Health Organization, set up an Ischemic Heart Disease Register in September 1969 that has been maintained up to the present. Virtually all cases of acute ischemic heart disease occurring in the inhabitants of Helsinki have been registered. The criteria for the diagnosis of acute ischemic heart disease are those that have been outlined by a subcommittee of the World Health Organization and are common to all ischemic heart disease registers used in several European countries (10).

Measurements of subjects' recent life changes were carried out by nurse-interviewers who used a Finnish translation of the Schedule of Recent Experience (SRE) questionnaire. This questionnaire, described in detail in previous reports (5–8), is composed of 42 life-change questions. Respondents indicate which, if any, of the 42 life changes they may have recently experienced and in which three-month interval over the past two years these events occurred.

As in previous studies with the SRE, the life changes themselves were scaled to obtain life-change unit (LCU) weights for the individual items (5–8). These LCU weights represent the average degrees of life change and readjustment necessary for an individual to cope with each life event. Even though previous studies of persons living in various countries (11, 12) have indicated a high degree of agreement on these LCU weights, and especially on the rank ordering of the 42 life changes by LCU weights, a rescaling of the life changes was carried out in Finland on a separate sample of 149 subjects. The results of this Finnish scaling study are shown in table 1. (Finns

who took part in the LCU scaling experiment were healthy men and women covering a wide age range; none of the persons whose names were gathered from the Ischemic Heart Disease Register participated in the scaling.)

There were 292 nearly consecutive entries in the Helsinki Ischemic Heart Disease Register for persons who had survived a definitive myocardial infarction and were less than 65 years of age. Complete information on the SRE questionnaire was collected from 279, or 95 percent of all possible subjects; the remaining five percent were either too ill to cooperate or refused cooperation. During approximately the same time period, the names of 286 subjects who were less than 65 years of age and had died abruptly of coronary heart disease were gathered from the register. The spouses of these persons, or on rare occasions a close relative, were contacted for interview with the SRE questionnaire. Twenty-five of the 286 subjects proved to have no spouse or close relatives from whom information on life changes could be obtained. An additional 24 subjects did have such a relative, but the interviewers were unable to make contact with them. Only 11 relatives who were contacted refused the interview. Hence, complete data on life changes were collected for 226 persons who died of coronary heart disease, or 79 percent of all possible cases; in only five percent of the cases did relatives who were contacted refuse to be interviewed.

On the basis of the results of previous investigations, it was hypothesized that subjects who had a myocardial infarction or an abrupt coronary death would reveal an increase in LCU totals during the two years prior to their infarction or death (6–8). Because of this hypothesis, as well as the fact that LCU comparisons were made between six-month periods for the same groups of persons, the one-tailed t test for correlated means was used. For intergroup comparisons, however, the standard two-tailed t test was used.

TABLE 1
Life Change Events and Their LCU Weights Scaled for Finland

Event	Finnish LCU Weight
HEALTH	
Recent illness (in bed for a week or hospitalization)	62
Change in heavy physical work or exercise	19
Change in sleeping habits	15
Change in eating habits	11
WORK	
Recently out of work	50
Recently fired from work	50
Retirement from farming, forestry, or industry	40
Change to new type of work	36
Change in work responsibilities	29
Troubles with boss	22
Work or life going well (awards, achievements, etc.)	20
Correspondence courses (home study)	17
Change in hours of work a day	13
HOME AND FAMILY	
Concern over health of family member	54
Recently married	50
Separation from wife due to marital problems	48
Gaining a new family member (in the home)	39
Separation from wife due to work	34
Engaged to be married	32
New home improvements	26
Son or daughter leaving home	23
Wife began or ended work	23
Troubles with in-laws	22
Change in get-togethers with friends	21
Change to a new residence	15
Change in get-togethers with relatives	13
Vacation	11
PERSONAL AND SOCIAL	
Death of wife	105
Divorce	80
Held in jail	64
Sexual difficulties	41
Change in number of arguments with wife	40
Death of a close relative	39
Financial difficulties	38
Major decisions regarding the future	38
Death of a close friend	34
Unpaid bills leading to threatened legal action	26
Recent purchases worth more than 8,000 Fmk ($2,000)	22
Change in religious or political convictions	20
Change in personal habits	12
Recent purchases worth less than 8,000 Fmk	11
Minor violations of the law	7

RESULTS

Myocardial Infarction and Recent Life Changes

Since it had been previously demonstrated that a person experiences more life changes several months before, and after, major illness or injury (13), it was important to divide the 279 survivors of a definitive myocardial infarction into two subgroups on the basis of their physical health during the two years prior to their infarctions. We found that 113 subjects had suffered a significant illness, generally of cardiovascular origin, during the two years prior to their infarctions. The remaining 166 subjects recalled no illnesses during the two years before their infarctions. Only in the cases of subjects who had been in good health during the two years before their infarctions could an increase in the number of recent life changes be clearly unrelated to other physical illness or injuries. (In Scandinavian samples, many life changes are determined by the season of the year, e.g., vacations in July, overwork during winter; the interval most comparable to a given six-month period, therefore, is the same six-month period in the preceding year.)

As shown in table 2, the mean LCU totals for the final six months for survivors of myocardial infarction with preinfarction illnesses was 74 LCU. The mean LCU total for this group of subjects during the comparable six-month period one year earlier was 52 LCU. This 42 percent increase in the six-month LCU total was significant at the level of $p<.025$. Similarly, survivors of myocardial infarction who were in good health during the two years

TABLE 2
Comparison of Six-Month LCU Totals

Group	Number	Final Six-Month LCU Totals (Mean ± S.E.)	Six-Month LCU Totals One Year Earlier (Mean ± S.E.)	Significance
Survivors of myocardial infarction				
Recent illness	113	74 ± 6.2	52 ± 6.2	$p < .025$
No recent illness	166	39 ± 3.9	23 ± 2.8	$p < .005$
Sudden death				
Recent illness	65	77 ± 7.7	44 ± 7.8	$p < .005$
No recent illness	61	51 ± 8.0	21 ± 4.2	$p < .005$
Delayed death				
Recent illness	49	96 ± 11.7	56 ± 9.1	$p < .025$
No recent illness	35	42 ± 7.7	35 ± 10.2	n.s.

prior to their infarctions had a mean LCU total for the final six months of 39 LCU, compared with a mean LCU total of 23 for the comparable six-month period one year earlier. This 69 percent increase in the subjects' mean six-month LCU total was significant at the $p<.005$ level of confidence.

Intergroup comparisons between survivors of myocardial infarction with and without preinfarction illnesses indicated that those with preinfarction illnesses had significantly higher six-month LCU totals for both the six months immediately prior to the infarction and for the six-month interval one year earlier than did their counterparts who reported good health prior to their infarctions ($p<.01$).

Acute Coronary Death and Recent Life Changes

There were 126 subjects who died within an hour of their initial onset of symptoms. This subsample was called the "sudden death" group and was itself divisible into 61 subjects who had apparently been healthy during the two years prior to their sudden death and 65 subjects who reportedly experienced significant illnesses during this two-year period. There were 100 subjects who died of their acute coronary episode between one hour and 28 days after the onset of symptoms; they were labeled the "delayed death" group and were divided into 35 subjects who had apparently suffered no significant illness and 49 who reportedly did experience illnesses during the two years prior to death (the remaining 16 subjects in the delayed death group had possibly died of causes other than their coronary heart disease, e.g., renal failure, and were therefore excluded from the following analyses).

Table 2 shows that, for sudden death subjects who experienced illnesses during the two years before their deaths, the mean LCU total for the final six months was 77. Their mean LCU total for the six-month period one year earlier was 44. This 79 percent increase in the LCU total was statistically significant ($p<.005$). Sudden death subjects with no illnesses during the two years before their deaths had a mean LCU total for the final six months of 51. In comparison with their mean LCU total for the six-month period one year earlier, which was 21, these subjects showed a 143 percent LCU increase ($p<.005$).

Intergroup comparisons between the two subsamples of sudden death subjects indicated that, for both six-month periods under study, those who had prior illnesses had significantly higher LCU totals than did their counterparts who had no recent illnesses ($p<.025$).

Finally, table 2 indicates that, for the delayed death subjects with previous illness during the two years before death, a 71 percent LCU increase (from 56 to 96) was seen over the two six-month periods under study ($p<.025$). Delayed death subjects with no recent illnesses showed an increase in six-month LCU totals of only 20 percent (35 to 42), which was not statistically significant.

Intergroup comparisons showed that only for the six-month period immediately before death did the delayed death subjects who had prior illnesses demonstrate a significantly higher mean six-month LCU total than subjects who had reportedly experienced no illnesses before death ($p<.01$).

Degree of Increase in Recent Life Changes

Not all survivors of myocardial infarction or coronary death subjects showed an increase in final six-month LCU totals. Some persons experienced a marked increase; others reported slight to moderate increases. In order to examine the distribution of subjects according to their recent increases in LCU totals, only survivors of myocardial infarction and coronary death subjects with no premorbid illnesses during the two years under study were compared. In this way, all life changes reported up to the time of infarction or death were presumably due to the subjects' accustomed activities of middle age rather than the result of previous illnesses. Finally, criteria were established for what constituted "marked," "moderate," and "no" final six-month LCU increases.

There were 166 survivors of myocardial infarction who reported no preinfarction illnesses; 96 coronary death subjects reportedly experienced no illness during the two years prior to their deaths. A marked increase in recent life changes was defined as an increase in the final six-month LCU total of at least 100 percent over the six-

TABLE 3
Comparison of Increase in Recent Life Changes, in Percentages

Degree of Increase	Survivors of Myocardial Infarction (N = 166)	Coronary Deaths (N = 96)
Marked	29	38
Moderate	35	33
None	36	29

month LCU total for the same interval one year earlier. In addition, subjects were included in this category if their LCU totals were zero for the final six-month period of the previous year and were 26 or more for the final six months before myocardial infarction or death. (An increase of 26 was the mean LCU increase for those subjects who reported a final six-month LCU increase of 100 percent.)

Moderate increase in recent life changes was defined as an LCU increase of one to 99 percent for the final six-month period over that for the corresponding period one year earlier. In addition, subjects were included in this category if their LCU totals were zero for the final six months of the previous year and were from one to 25 LCU for the final six months of the study period. Also included in this category were those few subjects whose LCU totals were 26 or more for the final six months of the previous year (an "early" LCU elevation), although their six-month LCU totals for the final year were 25 or less.

The remaining subjects comprised the group with no recent increase in life changes—those who reported 0–25 LCU for the final half of the previous year and an equal or smaller LCU total for the six-month period immediately prior to myocardial infarction or coronary death.

The percentages of subjects falling into each of the three divisions outlined above are shown in table 3. It can be seen that subjects with a "marked" increase in recent life changes accounted for 29 percent of the myocardial infarction group and 38 percent of the coronary death group, whereas for subjects with "no" recent life changes these percentages were, in effect, reversed.

DISCUSSION

Survivors of myocardial infarction demonstrated significant increases (42 to 69 percent) in their final six-month LCU totals over those for the corresponding interval one year earlier. This final six-month LCU increase was seen despite a relatively high six-month LCU total for the final half of the earlier year for those subjects with recent illnesses. Hence, whatever the subjects' LCU "baseline," a relative increase in their LCU totals appeared to herald the onset of new coronary disease.

With the exception of the relatively small subgroup (N=35) of delayed death subjects who experienced no recent illnesses prior to their deaths, significant increases were also seen for sudden and delayed death subjects in their final six-month LCU totals. The two sudden death subsamples and the delayed death subsample with recent illnesses reported increases of 71 to 143 percent in their final six-month LCU totals compared with the same period one year earlier. It appeared, then, that those subjects with the most severe coronary crises—sudden death—reported the highest increases in recent life changes, delayed death subjects reported the next highest, and survivors of myocardial infarction reported the smallest increases in recent life changes. As was the case for survivors of infarction, the coronary death subjects with recent illnesses showed higher LCU totals during the two years under study than did those who were in good health during this time.

The demonstration of a significant increase in recent life changes for both survivors of myocardial infarction and coronary death subjects during their final six months before infarction or death implies a precipitating influence of these life changes upon the onset of their illness or death. It would seem to follow that if many of these subjects had not been exposed to this significant increase in demands on their lives, they might not have developed an infarct or have died at the time that they did.

An examination of the percentages of selected Finnish survivors of infarction and coronary death subjects who experienced marked, moderate, or no recent increases in life changes can be compared with the percentages of myocardial infarction and sudden death subjects who showed marked, moderate, or no elevations of serum cholesterol or systolic blood pressure. Data for these two well-established "physical" risk factors for coronary heart disease have been taken from a large American prospective study of 3,049 middle-aged men followed for the development of coronary heart disease over four and a half years (14). Two hundred of these American men developed a definitive myocardial infarction; 57 others died of coronary heart disease during the follow-up period. Table 4 shows the percentages of these survivors of myocardial infarction and coronary death subjects who

TABLE 4
*Comparison of Elevations in Serum Cholesterol Levels and Systolic Blood Pressure, in Percentages**

Degree of Elevation	Survivors of Myocardial Infarction (N = 200)	Coronary Deaths (N = 57)
Serum cholesterol		
Marked	31	51
Moderate	36	40
None	33	9
Systolic blood pressure		
Marked	14	14
Moderate	70	72
None	16	14

*Data from Rosenman and associates (14).

LIBRARY

demonstrated marked, moderate, or no elevations of their serum cholesterol and systolic blood pressure. (Marked serum cholesterol elevations were defined as those above 259 mg./100 cc., moderate values were between 220 and 259 mg./100 cc., and low values were those less than 220 mg./100 cc. Similarly, marked systolic blood pressure elevations were defined as those greater than 159 mm. Hg; moderate values were between 120 and 159 mm. Hg; and low values were those less than 120 mm. Hg.)

Subjects with markedly elevated serum cholesterol levels accounted for 31 percent of survivors of myocardial infarction and 51 percent of coronary death subjects, while those with low levels accounted for 33 percent and nine percent, respectively. Subjects with marked elevations in systolic blood pressure accounted for 14 percent of each group, while those with low levels accounted for 16 percent of survivors of myocardial infarction and 14 percent of coronary death subjects. Thus, although not all of our Finnish subjects reported marked or moderate increases in recent life changes prior to infarction or death, the case is only slightly better for the distribution of the two important physical risk factors documented in the American study.

In the study by Rosenman and associates (14), of all subjects whose systolic blood pressure was greater than 159 mm.Hg., approximately 5.4 percent developed an infarction and/or coronary death during each follow-up year. Of all the subjects whose serum cholesterol values were greater than 259 mg./100 cc., approximately 3.1 percent developed an infarction and/or coronary death during each of the follow-up years. Hence, between 95 and 97 percent of all subjects with markedly high values for either of these two physical risk factors for coronary heart disease do *not* develop myocardial infarction or coronary death the following year. It may therefore be useful to include such possible precipitating factors as subjects' recent life changes in future prospective studies of coronary heart disease, since they may predict higher percentages of subjects who will develop myocardial infarction or coronary death during the following year than is possible with the currently used risk factors.

REFERENCES

1. Keys A (ed): Coronary Heart Disease in Seven Countries, American Heart Association Monograph No 29. New York, American Heart Association, 1970
2. Kannel WB, Castelli WP, McNamara PM: The coronary profile: twelve-year follow-up in the Framingham study. J Occup Med 9:611–619, 1967
3. Friedman M, Rosenman RH: Association of specific overt behavior pattern with blood and vascular findings. JAMA 169:1286–1296, 1959
4. Spain DM, Bradess VA: Sudden death from coronary heart disease: survival time, frequency of thrombi, and cigarette smoking. Diseases of the Chest 58:107–110, 1970
5. Rahe RH: Life crisis and health change, in Psychotropic Drug Response: Advances in Prediction. Edited by May PRA, Wittenborn JR. Springfield, Ill, Charles C Thomas, 1969, pp 92–125
6. Theorell T, Rahe RH: Psychosocial factors and myocardial infarction, I: an inpatient study in Sweden. J Psychosom Res 15:25–31, 1971
7. Rahe RH, Paasikivi J: Psychosocial factors and myocardial infarction, II: an outpatient study in Sweden. J Psychosom Res 15:33–39, 1971
8. Rahe RH, Lind E: Psychosocial factors and sudden cardiac death: a pilot study. J Psychosom Res 15:19–24, 1971
9. Vital statistics and causes of death, in World Health Statistics Annual: 1967. Geneva, World Health Organization, 1970
10. World Health Organization: Ischaemic Heart Disease Registers: Report of the Fourth Working Group. Copenhagen, Regional Office for Europe, WHO, 1970
11. Rahe RH: Multi-cultural correlations of life-change scaling: America, Japan, Denmark, and Sweden. J Psychosom Res 13:191–195, 1969
12. Rahe RH, Lundberg U, Bennett L, et al: The social readjustment rating scale: a comparative study of Swedes and Americans. J Psychosom Res 15:241–249, 1971
13. Rahe RH, Arthur RJ: Life events surrounding illness onset. J Psychosom Res 11:341–345, 1967
14. Rosenman RH, Friedman M, Jenkins CD, et al: Recurring and fatal myocardial infarction in the western collaborative group study. Am J Cardiol 19:771–782, 1967

Pediatric-Child Psychiatry Collaboration in a Health Maintenance Organization

BY NORTON GARBER, M.D.

The author describes a collaborative program between the child psychiatry and pediatric services of a prepaid group practice plan that included weekly meetings between the psychiatrist and the pediatric staff, meetings also involving other disciplines, and clinical evaluations of referred patients. The advantages of this kind of approach, especially its educational and preventive aspects, are described, and it is proposed as a possible model for interdisciplinary work that will help realize the goal of comprehensive health care.

THE CURRENT CRISIS in health care delivery has generated wide interest and debate. Political, financial, and philosophical issues have influenced proposed solutions and overshadowed medical considerations, while even in medical discussions the focus has been on statistical rather than clinical issues. As a reflection of this, the future role and function of psychiatry and child psychiatry as well as other disciplines remain quite unclear. What is no longer in doubt, however, is that change in our systems of health care delivery is forthcoming. Therefore, what is needed to contribute to a more relevant and meaningful discussion is an examination of clinical experience in those systems which are now being promulgated as "new" solutions to this crisis.

The health maintenance organization (HMO), which in practice is usually a prepaid group practice medical care program, is one such system that has provided new opportunities to explore health care services. Recent reports (1, 2) have reviewed the utilization and feasibility of child psychiatry within an HMO. This report, which will focus on the HMO as a unique setting for pediatric-child psychiatry collaboration, will describe and evaluate this collaboration as a new working model of health care services for children.

Comprehensive medical care of the child has been defined as:

> the prevention and treatment of physical disease, and the supervision of healthy growth and development, physical and psychological. Through his comprehension of the physical, psychological, and social forces that influence the child, the pediatrician enables the child and his family to take an active role in solving their health problems (3).

Dr. Garber is Assistant Clinical Professor, Yale Child Study Center, and Staff Psychiatrist, Yale University Health Services, Division of Mental Hygiene, Box 1505-A, Yale Station, New Haven, Conn. 06520.

This approach demands an involvement by pediatrics with psychiatry in mastering the psychological developmental aspects of child care and points in the direction of a true collaboration for comprehensive pediatric care.

The child psychiatrist has always had an interest in collaborative work with pediatricians. There are several reasons for this: First, his training may have had a collaborative emphasis, for in most training centers the child psychiatry fellow works as a consultant to the pediatric house staff on the wards and in the clinics. Second, this training has a distinct developmental orientation, which means (among other things) that the child psychiatrist shares with the pediatrician the necessity for a vital appreciation and active consideration of the growing child in physical health as well as illness. Also, since psychological disturbances in childhood are often intimately involved with disruptions in physiological functioning and development, pediatrician and child psychiatrist are drawn together once more. Finally, with both disciplines firmly anchored on principles of growth and development, they share the concept of prevention as an active, daily concern.

In spite of this, our systems of private practice and child guidance clinics have often poorly served the interests of comprehensive pediatric care. They have operated too often in a fragmented fashion in which referral to the psychological specialist substitutes for meaningful collaboration.

The objectives of health maintenance organizations include the maintenance of health and the prevention of disease; these goals are pursued through the team practice of medicine, which has mechanisms to integrate a disjointed, overspecialized, and uncoordinated health care delivery system (4). The health maintenance objective carries with it the necessity for the primary physician to expand his information and awareness as he shifts away from a "medical crisis" focus. The team practice concept necessitates the exploration and application of new approaches to health care and the assimilation of experience in new ways.

The obvious congruity between the objectives of health maintenance organizations and the expertise, interest, and experience of the child psychiatrist should lead toward the establishment of a truly coordinated and comprehensive child health maintenance program that promotes normal growth and development. Such a program might be produced by a team consisting of the pediatrician working in collaboration with the child psychiatrist. The opportunity to apply these ideas in a working model became available with the establishment of the new Yale Health Service.

SETTING

The Yale Health Service is a voluntary prepaid group practice medical care facility that opened on July 9, 1971. Sponsored by the university, it offers complete medical facilities and services provided mainly by a full-time staff of physicians with university appointments. A 66-bed intermediate care facility is housed within the building; care for more serious illness is provided through insurance coverage. Psychiatric consultation and evaluation is offered for adults and children; if there is referral for private therapy the patient pays part of the cost under a coinsurance arrangement. The average pediatric population this first year was 2,807, consisting of 37 percent employee children, 52 percent faculty children, and 11 percent student children.

The pediatric service includes four Yale-trained pediatricians and one nurse practitioner. One pediatrician had had many years of experience in private practice, another had been director of pediatric outpatient services at Yale-New Haven Hospital, a third had recently returned from postresidency military service, and the fourth had just completed his pediatric residency training. The nurse practitioner had had approximately six months' experience in a hospital clinic and private pediatric office. As the child psychiatrist, I had had three years' experience in private practice and in the Yale Department of University Health. During this first year of the service I devoted ten hours weekly to the pediatric-child psychiatry collaboration.

GOALS AND OBJECTIVES

Whereas the adult and student psychiatric division of the Yale Health Service had previously existed as part of the predecessor Department of University Health, both the child psychiatry and pediatric services were new. This largely freed us from the bonds of precedent but it also deprived us of the background experience that can be helpful in developing such services. We were uncertain as to what demand for service would emerge from the population, especially since we knew of no comparable population in an HMO. Although utilization was hard to predict, we spent considerable time trying to delineate the goals and the mode of operation for child psychiatry. A statement of policy and procedures that discouraged self-referral and encouraged initial pediatric consultation was devised and circulated to the staff. It read in part:

> [The policy] is designed to deliver the best possible psychiatric service to dependent patients under 18 years of age within the limits of available child psychiatric time. It provides for prompt direct consultative services for psychiatric disorders. In addition, it is an attempt to move towards a true comprehensive approach to child care on the part of the pediatric service which, hopefully, will respond increasingly to stress situations in psychological development before the occurrence of true psychiatric crises.

An initial decision was made to use this first year as a period to evaluate needs and objectives. Notes were kept on all the discussions that took place during the year and were reviewed at the year's end.

THE OPENING PHASE

During the first month I made a particular effort to establish collaboration as a vital and routine part of the pediatricians' work. Although collaboration as such was not foreign to any of them it still seemed important for me to prove its worth once again. I tried to accomplish this in three ways. First, I had to offer something that was needed, so I offered to accept referrals for psychiatric evaluation, thereby fulfilling a need of which they were well aware. Second, I sought their aid in planning and setting up the collaboration. Active and enthusiastic participation in such a program depends partly on sharing the formulation of the program so that it is felt to be truly "our" program. Finally, if I was to expect their interest in a psychological viewpoint I had to demonstrate my interest in their pediatric work. For this reason, and because I wanted to watch each of them work as well as refresh my own pediatric experience, I spent most of my time during the first month observing the pediatric staff in their work. My interest in observing their daily work could also be expected to reinforce their appreciation of the importance of their "routine" contacts with the children. From a psychological viewpoint no experience between a child and a pediatrician is routine.

METHODS OF COLLABORATION

During the course of the year, pediatric-child psychiatry collaboration assumed four forms: one-hour weekly meetings with the pediatric staff, ad hoc team meetings that included other disciplines as well as pediatrics, one-to-one meetings with individual pediatric staff members, and clinical evaluation of referred patients.

The weekly meeting quickly assumed the pivotal role in our collaboration. A determining factor was the relative inviolability of the time: this was the only time during the week that the pediatricians were freed from direct clinical demands. Establishing this "sacred" period of time, which was partly a result of my insistence, reflected my own appreciation of its importance; it was an appreciation gained through my own work with patients in psychotherapy. The meeting provided a forum for exchange of views and feelings among the staff, fulfilling their need not only to discuss patients and consider possible psychiatric referrals but to raise clinical developmental problems that emerged in their work. At times there were issues that called upon my expertise in child psychiatry but equally often there was an open discussion eliciting the experience of the pediatricians themselves. Often a case would be followed for several weeks while suggestions were offered for interview techniques and the synthesis of material.

The following brief notes convey some of the sense of these discussions:

> Parents requested guidance for sleep disorder in a 2½-year-old child whose younger sibling had recently died. The discussion included an understanding of the meaning of death for a 2½-year-old, considerations of separation anxiety, and the parents' own emotional state. Further symptomatology (hysterical crying, increase in masturbation) was revealed through a review of the child's clinical status. The question of what support the pediatrician can give the parents and what they are actually asking for was discussed.

> Advice on toilet training. Should the pediatrician initiate this discussion with parents and, if so, at what point? How active a role should the pediatrician take? What should he say to the parents and what, in turn, should the parents say and do with the child? How actively involved should he get?

> On a routine visit for annual physical examinations a mother mentioned that she and her husband were separating. Brief questioning by the pediatrician revealed that visitation rights for the 6-year-old and 2-year-old were likely to become issues of contention. What considerations of child advocacy and developmental factors are important in outlining an appropriate visitation procedure? What is the obligation of the pediatrician to advise and educate the parents regarding these developmental factors, and what is the possibility of offering them his auspices as an alternative to a legal forum?

The psychiatrist and individual pediatricians had frequent informal meetings, particularly to discuss specific findings following the psychiatric evaluation of a child. We tried to answer the referring questions as well as to discuss recommendations for further medical or psychiatric management. At times specific issues in clinical diagnosis were also reviewed informally on a one-to-one basis. In adapting to a pediatric practice rhythm I made an effort to keep time open to encourage informal contacts.

The general areas covered in our discussions included the following:

1. Management of normal developmental crises by pediatrician and/or parent—e.g., toilet training.
2. Reaction of parent to illness, death, or physical defect of child or sibling.
3. Reaction of child to physical illness or defect of parent or sibling.
4. Reaction of child to his own physical illness or defect.
5. Psychophysiological developmental disturbances—e.g., enuresis, encopresis, sleep or eating disorder.
6. Somatic disorders—e.g., asthma.
7. Parental adjustment to the changing role of the adolescent in the family.
8. Changes in the security of the household—e.g., frequent moves and lengthy periods in a foreign environment.
9. Disruption of the parental coalition.

As the year progressed it became clear that certain clinical problems demanded evaluations that routinely involved other disciplines: neurology, psychology, otolaryngology, ophthalmology, and learning specialties. These clinical difficulties included developmental problems of infancy, visual and auditory disorders, and learning disorders. Our first effort at a team approach, which dealt with learning disorders, was put into effect under the coordination of the pediatrician. It involved pediatrics, psychiatry, psychology, nursing, ophthalmology, and optometry. The approach evolved from a series of meetings in which we educated ourselves through readings, discussions, and lectures by outside experts. After reviewing and pooling our experiences, we formulated a team evaluation approach. This provided for an initial developmental screening by the pediatric nurse practitioner, and then evaluations by the pediatrics, ophthalmology, psychology, and psychiatry services—all coordinated by the pediatrician.

Finally, I conducted clinical evaluations of 30 referred patients, seeing all the children and family members personally. The effectiveness of the screening and referral practices of the pediatrics service was reflected in the appropriateness of the referrals, in the fact that there was only one dropout following referral, and in our impression that almost all of the patient families accepted the final recommendations well. I found it helpful to have heard something about the families from the pediatricians beforehand and to have received before evaluation a preliminary information sheet given the families by the pediatrician and completed by them.

UTILIZATION OF THE EVALUATION SERVICE

A total of 30 children and their families were seen directly for psychiatric evaluation. This represented approximately half the cases discussed in my weekly meetings with the pediatricians. The utilization rate for psychiatric evaluation was 10.6 per thousand enrollees per year.[1] Of these, 26 were referred by pediatrics and the rest were self-referred. The average number of sessions per evaluation was 3.7. Further therapy was recommended for 17 of the 30.

These statistics may reflect certain conditions prevailing only in the first year of the service; these would include the existence of families who were waiting for the opening of the service to request help for long-standing problems. But this might have been counter-balanced by the lag before the pediatricians became sufficiently acquainted with their patients to be able to detect difficulties and prepare them for referral.

DISCUSSION

On the basis of this first year's experience a number of features have emerged that reaffirm the importance of such a collaboration, demonstrate the advantages of such

[1] Other studies, while not altogether comparable, showed rates per 1,000 enrolled population of 12.6 per year (1), 10 per year (5) and 70 over three years (6).

work in an HMO setting, and suggest this kind of collaboration as a model for comprehensive health service. Among the advantages are:

1. The possibility for a more effective application of clinical services for many (if not most) clinical problems because of increased flexibility, continuity, and feedback. The pediatrician remains a constant figure available to the child, overseeing his development and coordinating additional information. Psychiatric problems are less likely to be seen as a signal for referral to another physician or clinic than as an opportunity for concerted, collaborative effort and evaluation.

2. More efficient, more appropriate, and more specific use of child psychiatric time, with concomitantly greater use of other qualified personnel, including nurse practitioners.

3. A coordinated team approach to certain combined clinical entities, thus avoiding the fragmentation, confusion, and delay often encountered when individual practitioners or agencies are involved.

4. The emergence of significant patterns when we were confronted in our meetings with the way in which certain parents sought medical advice for a child and what they then did with this advice. For example, a mother's behavior in consulting one specialist after another was explored in terms of her need to avoid confronting her child's defect and her identification with it. We also explored the physician's reaction to a patient who did not follow his advice but sought "better" advice. Once again, the availability of a unified medical record documented and dramatized such a pattern and made it more difficult to overlook.

5. Greatly enhanced opportunities for education. In the weekly meeting with the pediatric staff I tried to transmit those principles of psychiatric technique and theory that would be directly useful to them. Early intervention and prevention were stressed through exploration of issues of cause and effect and patterns of normal development. We discussed interview techniques, observational skills, and the kind of synthesis of this material that is necessary for a psychological formulation. The meeting also served as a forum for pediatric peer supervision, which was supportive and helped to reduce pressures toward isolation (7). The regular feedback of information from the evaluations to the pediatricians could be used not only in guiding them in their further pediatric work with a particular patient but in aiding them to sharpen their own psychological evaluative skills.

6. Many opportunities for studying the impact of various interventions. Since an HMO provides a defined population, efforts to move toward prevention and early intervention should eventually be reflected in a decrease in significant psychopathology needing psychiatric evaluation. Similarly, clinical hypotheses can more easily be tested because of the availability of centralized information. For example, in reviewing the material discussed by the pediatricians this past year I discovered relatively little discussion of children with chronic illness who ordinarily would be expected to present problems in psychological development. Whereas an observation like this might be overlooked in an isolated pediatric practice, it would more readily emerge in the kind of collaboration described here. Still another example of the potential of such group work is our plan to periodically retrieve all records of patients with learning disorder to review the efficacy of our evaluation program.

For those cases in which there was a recommendation for further therapy outside the service, there may have been a disruption in the kind of continuity we were trying to achieve. Although the Yale service does not offer psychiatric therapy at this time, other HMO-type plans do. The initial benefit level in any program is often based upon the experience of others as well as on actuarial predictions. However, analogous programs have been very few, and predictions have necessarily been based on the experience of groups that did not have such comprehensive medical care available to them as ours does.

Even more significant, however, is the fact that predictions of utilization have been based on a view of psychiatry as a therapeutic specialty—and to a great extent, it *has* been this. Secondary prevention (early diagnosis and treatment) has been achieved only sporadically and efforts to move toward primary prevention (elimination of the causes of disorders) have been largely disappointing. The community mental health center represents but the latest of these efforts toward prevention; the results are not yet conclusive.

There is no doubt that in our first year of pediatric-child psychiatry collaboration in the Yale Health Service we were able to operate on a secondary preventive level to a greater extent than any of us had done previously in our individual work. For the pediatrician it was not only easier to act on psychological problems but harder to ignore them. Cases often came under review and discussion well before distressing symptomatology summoned the attention of parents or school. However, what was even more exciting was the recognition of the potential of a pediatric-child psychiatry team to work in a primary preventive mode. If the principles of psychodynamic development have validity in psychiatry, it stands to reason that immediate response to the specific needs of the developing child and his family should prevent serious psychological distress in many instances. The pediatrician is "on the scene" from the mother's pregnancy onward and, provided with the structure and support of the kind of collaboration described here, should be able to oversee the child's development, thereby providing continuous and informed guidance and (when necessary) early intervention. Although the long-term nature of such an endeavor prevents immediate answers, both the number of children seen in a group practice and the facilities for collecting information in this kind of setting provide the feedback needed to guide these efforts.

If such an attempt at primary prevention is even partly successful it should eventually be reflected in a lower rate of utilization of psychological treatment. Earlier predictions would have to be revised and more comprehensive psychiatric coverage could be offered. Furthermore, if such collaboration is successful, it can provide a model for other interdisciplinary work (as it has in our plan) and

will be a major step toward the realization of the goal of comprehensive health care.

REFERENCES

1. Goldensohn SS, Fink R, Shapiro S: The delivery of mental health services to children in a prepaid medical care program. Am J Psychiatry 127:1357–1362, 1971
2. Goldensohn SS, Fink R, Shapiro S: Referral, utilization, and staffing patterns of a mental health service in a prepaid group practice program in New York. Am J Psychiatry 126:689–697, 1969
3. Solnit AJ, Senn MJ: Teaching comprehensive pediatrics in an outpatient clinic. Pediatrics 14:547–556, 1954
4. Murray RH, Messenger KP: Consideration of health maintenance organization at a public medical school. Bloomington, Ind, Department of Community Health Science, Indiana University School of Medicine and the Regenstrief Institute for Health, Jan 28, 1972. (processed)
5. Chess S, Lyman MS: A psychiatric unit in a general hospital pediatric clinic. Am J Orthopsychiatry 39:77–85, 1968
6. Novack A, Abramovitz R: Personal communication, Sept 21, 1972
7. Solnit AJ: Eight pediatricians and a child psychiatrist: a study in collaboration, in The Teaching of Dynamic Psychiatry. Edited by Bibring GL. New York, International Universities Press, 1968, pp 158–174

Questions of the Month

Directions: Each of the questions or incomplete statements below is followed by four or five suggested answers or completions. Select the *one* that is BEST in each case.

Question 1 Under usual clinical conditions, if the Rorschach indicates a greater degree of psychological disturbance than is apparent in the clinical interview of an adult patient, the most likely reason is that the

(A) Rorschach test has very limited validity for assessing psychopathology
(B) patient is intelligent and skilled at concealing information
(C) Rorschach test taps a layer of functioning obscured by ego defenses
(D) interview is consistently less valid than the Rorschach as a diagnostic procedure
(E) patient is suffering from pseudoneurotic schizophrenia

Question 2 For which woman would the risk of bearing a child with Down's syndrome be greatest?

(A) A woman of any childbearing age who is a translocation carrier
(B) A woman who is not a translocation carrier but who has a child with Down's syndrome
(C) A primagravida under 20 years old
(D) A 35-year-old woman with four children, one of whom has Down's syndrome
(E) A primagravida over 45 years old

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 1236. References for the questions are supplied on page 1241.)

Changing Human Service Delivery Systems: Their Influences on Psychiatric Training

BY ROBERT S. DANIELS, M.D.

Human service delivery systems are the focus of problems and controversy in 1973. The systems that pertain to mental health and illness have incorporated many of the innovations in organization, delivery, and administration that appeared in the 1950s and 1960s. The author argues that these may evolve into arrangements in which mental health delivery is either separate (as in the community mental health center) or integrated in varying degrees with other health care systems and that the choice of arrangements will affect the training of psychiatrists.

DURING THE 1970s this country will struggle with complex social problems as it strives for a better quality of life for its entire population. The human services—educational, health, legal, and social services—have key contributions to make. These services, often organized to promote the growth, development, and adaptation of individuals, families, and communities, have more often served only to assist people who are already in serious difficulty. In this respect, these services are judged by many to be inadequate. Reorganization, innovation, and experimentation with careful evaluation are indicated.

The problems that are common to most human service systems include: 1) professionals who seem more interested in maintaining their methods and standards than in altering their methods of service delivery to respond to client need; 2) bureaucracies that also seem more interested in sustaining themselves and their employees than in improving client services; 3) service systems that resist experimentation with new methods of human service delivery and new types of staff; 4) a public that has been unwilling to finance services at an adequate level (too many clients and too few services); 5) the lack of an effective, comprehensive system of service delivery; and 6) data that do not reveal which methods lead to what outcomes for which individuals and which communities.

The treatment of mental illness reflected many of these problems from the late 1940s to the 1960s. Revisions that were designed to correct some of these difficulties and deficiencies were sometimes consciously thought out, planned, executed, and evaluated; more often, however, they were the result of situations in which improvisations were necessary and a crisis was turned into a service delivery advantage. These changes included the multidisciplinary team, the therapeutic community, the "open door," a decrease in the size of institutions, early treatment close to the home community, psychiatric units in community hospitals, improved aftercare, and the use of new and different sources of manpower. The psychological sciences and services also became potential bridges among many services. They supplemented and complemented the medical, social, educational, legal, and other human services. These advances were amplified or initiated by improved drugs, a more sensitive and more involved community, and a more optimistic view of mental illness. An attempt was made to bring these strengths together and systematize them through the community mental health center. Although it added little that was new, this movement synthesized a mental illness service delivery system from the advances of the 1940s and 1950s.

Currently, the planner and deliverer of mental health and illness services needs to consider several complex questions. When should mental health or illness delivery systems be separated organizationally? When should they be a part of other systems? If they are to be combined, which system should be primary? What are the implications of various arrangements for the careers of psychiatrists and for psychiatric residency training? Is there likely to be a "best" way of accomplishing improved and more effective service? Or will there be multiple organizational methods based on consumer, public, and professional choice or local conditions?

Part of the problem with which mental health professionals struggle is the absence of a feasible national policy for an organizational or financial structure for treating mental illness, for treating physical illness, or for providing social services. This lack of a national policy results in a lack of clarity about future developments. Although the community mental health system format has now been in the process of formation and implementation for almost ten years, often the local and federal financial support to promote optimal and rapid development has not come forth. In fact, there has been almost no new funding in the last several years and it is unclear whether Congress, the federal administration, the public, and the bulk of professionals conceive of this method of service organization as really feasible in our present society. There is some current evidence that the nation is progressing toward policy formation in health and welfare services, although neither the organizational nor financial issues are yet settled. It is, however, unclear

Dr. Daniels is Professor and Director, Department of Psychiatry, University of Cincinnati, 234 Goodman St., Cincinnati, Ohio 45229.

whether services for the mentally ill will be included and, if they are included, what the quantity and quality of that inclusion will be.

No one has answers. It seems unlikely that there will be a single answer in a society that supports pluralistic systems of human service and consumer choice. The ultimate arrangements may vary according to the characteristics of the population, the geographic location, the population distribution, the professionals and institutions available, and, most of all, personal, client, and community choice.

The possibilities that must be considered are the community mental health center model (primarily a separatist model), a model in which mental illness services are integrated with other health and illness services, a model in which mental illness services are a part of other human service systems, and a multiservice model.

THE HEALTH AND ILLNESS SERVICE DELIVERY SYSTEM

Psychiatry has historically been a specialty within medicine. As such, it has been a potential or actual collaborator with other medical disciplines. From a relatively minor and unimportant position 30 years ago, psychiatry has increased in importance; it is now the specialty with the third largest number of practitioners and is now a recognized presence in most communities, medical practices, hospitals, and medical schools. These changes have not been accomplished easily; frequently psychiatry has been regarded by its medical colleagues as unscientific or unimportant. Further, the rest of medicine has envied psychiatry's more generous share of public training and research money. It is not surprising that psychiatry, discouraged by the attitudes and behaviors of the rest of medicine and encouraged by special public funding, has tended to establish its own systems of care and education or that there have been tendencies to separate the mental illness service system from medical care systems. The community mental health delivery system may have been a necessary step in the development of improved service systems for the treatment of mental illness. However, is it the best system? Or, if psychiatry and other services for the mentally ill received their appropriate support within a medical care system, might that be a better arrangement?

Currently, the medical service delivery system is the center of a good deal of national attention because of major organizational and financial difficulties. The major symptoms are: 1) inadequate outpatient medical care in terms of the number and types of personnel and the characteristics of the service delivery system; 2) uneven distribution of care in terms of geography, economics, and race; 3) a two-level system of finance in which the fee-for-service system is usually of higher quality; 4) inadequate financing for poverty and near-poverty populations; 5) a shortage of suitable preventive, rehabilitative, and sociopsychological services; 6) insufficient physician manpower and professional and institutional resistance to using the services of paraprofessionals; and 7) a fragmented system that the patient finds difficult to understand and manage.

Several approaches are currently under consideration by local, state, and federal governments to remedy this situation (1–3). They include: 1) the reorganization of medical care into closed systems in which comprehensive services are available from a single organization (e.g., health care corporations, health maintenance organizations, physician foundations) and 2) universal or national health insurance. These approaches are often combined in proposals for a closed panel group practice with prepaid capitation financing that delivers comprehensive services. The existing models that most closely approach this ideal are the Kaiser-Permanente plans, some union-sponsored or union-owned health plans, and certain physician-foundations or corporations.

The ownership and governance of such plans may be invested in communities, groups of consumers, unions, businesses, physicians, or hospitals. These ownership models may include or exclude physicians. Physicians may be salaried by the corporation or they may be separately incorporated and negotiate with the medical care corporation to provide services under contract arrangements subject to periodic review. The site of practice is often a health center and the physician on the staff may represent a number of specialties and general practice. The size of the population that can be best served is a controversial issue, but most experienced observers believe that 50,000 to 100,000 people is optimal.

Under these systems, ambulatory care could be delivered from a health center in which there would also be substantial preventive and outreach activities. They would be tied through ownership or contract arrangements to specialty outpatient services, hospitals, nursing homes, and rehabilitation services. It is hoped that this would provide ease of access, established criteria of eligibility, a common record, and smooth patient flow, with a minimum of the usual staff, organizational, and bureaucratic impediments.

Such plans as the prepayment capitation plans hope to distribute costs equitably and to stabilize the expense to the consumer and the public. Current evidence suggests that this method of service organization and financing decreases the use of the hospital (patients are hospitalized only 60 percent to 90 percent as often as in other systems with similar populations) and the frequency of the use of expensive services, particularly surgery. Other potential advantages are that the system can be manageable and responsive, that evaluative data can be gathered, and that the different elements can be varied and the results systematically appraised.

The place of mental illness services within such systems of care has remained unclear. Although the possibility of realistically including mental health services has been demonstrated (4–6), Congress, the Administration, and, most important, the public have not yet demanded their inclusion. The reason usually given is the possible expense—too many people requesting too much treatment. This belief is based, I believe, on the fantasy that

psychoanalysis or long-term intensive psychotherapy is the best treatment for everyone. In fact our experience suggests that most individuals and families want and benefit most from brief services within a brief time period. The exclusion of mental illness services from such plans may also be an expression of fear or prejudice.

What then might we anticipate under the best circumstances from the new health proposals?

1. The current system would evolve into something different; revolution now would only be destructive.
2. The minimum benefit package would be specific and clear and easily understood by consumers and providers.
3. The benefit package would include mental illness services. At a minimum this benefit package might include emergency services, up to 20 outpatient visits a year, general hospital services (including day care) for up to 30 days a year, consultation and education for other members of the medical and social service teams, and outreach and prevention services.
4. Further evolution of a benefit package should be possible with the expansion of benefits after the initial experiences.
5. The pluralism of our current system should continue. Any new system must be able to adapt to combinations of public and private insurance, or of both prepaid and fee-for-service mechanisms.
6. There should be compulsory coverage for the entire population.
7. Quality control and evaluation mechanisms should be built in from the outset.

EDUCATIONAL, LEGAL, AND SOCIAL SERVICE DELIVERY SYSTEMS

The evidence is that service delivery in other human service systems is no better than in the medical delivery system. The educational, legal, and social service delivery systems are occasionally excellent; more often they are plagued by client overload and show limited evidence of success. The problems seem similar to those found in medical service delivery: the bureaucracies are large, the professionals are bound to traditional techniques, the systems are unresponsive to consumer needs, the problems presented by users are overwhelming, the service system is underfinanced and is fragmented—not only within, but also in its connections to other service systems.

In each of these delivery systems mental health and illness services have an important role to play. These services are often provided in primary sites, where a considerable amount of preventive mental health work might be accomplished. Early intervention by professionals and nonprofessionals from other systems may obviate the later need for mental illness services. It is therefore the educator, the minister, the judge, the policeman, the social worker, and the physician who are likely to be the early contacts during the first symptoms of maladaption. These people are more often concerned with growth and development, how the individual and his family can be aided to develop their maximum growth and potential. These professionals often have not been specifically trained to be sensitive to the emotional needs of their clients or to deliver effective mental health service. Also, the other services are often unwilling or unable to finance the mental health and illness services that would be necessary to promote and optimize their own basic services.

Although mental health personnel within these other systems (especially psychologists and social workers) have occasionally provided direct service as actual members of the system, more frequently they have served as consultants—sometimes with individual clients or families, sometimes concerning classes of client problems, the training of personnel, or the functioning or politics of the agency. If properly utilized, psychiatrists can be useful as consultants and educators, contributing to policy formation and the improved functioning of the agency and its personnel as well as providing direct services to clients.

Another alternative exists, although it has been less frequently used in educational, legal, and social services. Mental health and illness services may be an essential and integral part of the service; agency personnel and mental health professionals may collaborate to provide the needed services. In the educational system this has taken the form of pilot projects in public schools or, in private settings, special procedures for entire schools. In the legal system such arrangements have occasionally occurred in particular courts, probation systems, or prisons. In the social service delivery system, a strong mental health and illness component is found more frequently. However, in this system (e.g., welfare or social agencies) the overwhelming demand for service is such that intervention for mental health or illness may be lost or compromised.

For the foreseeable future, it seems likely that the psychiatrist will work primarily as a consultant in the educational, legal, and social service delivery systems. To do this, he must be knowledgeable about individual, family, and small group behavior and understand both normal development and abnormal behavior. While his diagnostic and therapeutic skills may not be used often in direct service, they are essential underpinnings to his other services to the agency as an educator and consultant. The presence of these skills alone does not, however, make the psychiatrist an effective consultant. He must also be able to evaluate the agency's organization, administration, finance, and personnel. He must have some understanding of social systems and social fields and be able to conceptualize the problems and processes, plan and execute the interventions, appraise their effects, and adjust and respond accordingly. This process is fully as complex as individual, small group, or family treatment and requires training sequences that assist the psychiatric trainee to develop the necessary skills and competences.

SEPARATE VERSUS INTEGRATED SERVICES

The mental illness service system is confronted with a

complicated set of opportunities that require it to decide in a particular locale and under particular circumstances whether it will become or remain a separate mental illness delivery system, as in most community mental health centers, or attempt to integrate its services with other services. People's needs (individual, family, or community) are rarely satisfied within the framework of a single discipline or service system. Rather, they are multiple and span several areas of knowledge, involving several types of professionals and service systems. For the client every transfer from one system to another and every entry into a new one is a difficult process. The impediments include different locations, records, rules of eligibility, intake procedures, definitions of priorities and objectives, contacts with new people, and too often limited or poor communication among the professionals involved. If the new service is in a new location and the client has problems in getting there, the attrition rate is very high. Although we often speak of the client's lack of motivation, we rarely consider how difficult we make the processes that lead to service. Such problems are also often accentuated by cultural, racial, and economic differences between the servers and the served. Recent attempts to create a multiple service center under a single roof or under the auspices of a single organization recognize that fact (7). In reality, though, such multiple service centers are difficult to create and difficult to operate.

The alternative of entirely separate systems has some obvious strengths in this society. Such a system creates its own organizational, administrative, and political power base. It acquires its own resources by being its own advocate. It creates its own priorities through the agreement of its board, staff, and consumers. This authority and control offer greater flexibility if they are appropriately used. From this base it is then possible to cooperate with other systems to provide jointly sponsored services that may include a significant component for the treatment of mental illness or contributions that might promote mental health. The particular and separate treatment services we have developed in office, clinic, and hospital settings usually fit this model. The combination of services within a catchment area that has been synthesized into the community mental health center also corresponds to this model.

The challenges of such developments to evaluation and research are striking. We must learn more about which methods and procedures lead to what results. What are the significant variables and how can they be evaluated? What data could lead to rational decisions about the quantity and quality of services and expenditures? With increasing shortages of resources we must find a more rational way of approaching decisions or we will continue to squander scarce resources when there are citizens in very great need.

THE IMPACT OF NEW SERVICE DELIVERY SYSTEMS ON PSYCHIATRIC RESIDENCY TRAINING

The most important single issue in residency training is bringing together the trainee, the patient, and the teacher within an effective delivery system for the care of mental illness. In the past we have tended to accomplish the first of these conditions, bringing together trainees, patients, and teachers, without much difficulty. We have been less successful in establishing and participating in effective delivery systems. Usually we have presented opportunities for inpatient, outpatient, emergency, consultation, and related services in block rotations to the trainee. Although some progress has been made in psychiatric education, there continue to be great deficiencies (8, 9). There has been the possibility of selecting or rejecting whomever you please. There has been a mystique surrounding the selection of the "good" patient. There are frequently impediments among services within the same institution or department; each clinical service is insular and is under no obligation to accept any particular patient or group of patients, nor is there any real organizational encouragement to collaborate. There are often waiting lists and repeated intake and diagnostic interviews. These problems have resulted in a skewed view for the trainee of the services that are offered and a perpetuation of the fragmentation that the institution and professionals support and the consumers endure.

In many places, since services are delivered chiefly by the trainee, some of these artificial impediments and constraints are designed to protect the trainee and his training from too-high expectations of service. In most areas of this country we have not been willing to support our mental illness service systems, particularly those for the poor and near poor, at a level at which the trainee's presence is not absolutely essential. So long as this condition prevails, it is unlikely that the trainee will be educated in an ideal system or that he will have the experience of functioning within a comprehensive integrated system with both its difficulties and its advantages. Although the ideal may not be attainable, it is shortsighted to ignore the deficiencies in our current system and to foster training in which the trainee never confronts some of the real problems of mental illness service delivery.

Most psychiatric residency training programs are so deeply entangled in the problems of training, service expectation, and public financial support that they cannot undertake a new program without partially extricating themselves from the old. They fear the loss of their sources of financial support if they fail temporarily to meet the expectations of the public for continuing service.

The most common new pattern of service delivery is likely to be that of the health maintenance organization or health care corporation. Whether educational institutions should own these new service delivery systems is unclear at the moment. Most of the past examples of university ownership have not produced sensitive, responsive, or responsible service delivery. Clinical service needs are likely to be subordinated to so-called educational needs, with the result that both the clients' and trainees' needs are compromised.

Some new patterns of ownership are currently being explored. The most promising of these is ownership and governance by groups of consumers. This arrangement

places the educational institution in a contract relationship with the service organization. Each has authority and responsibility and the negotiations are conducted between equals. Each also has the option to leave the contract arrangement if it is not satisfactory. The risks for both are higher, but the likelihood of better service and training is probably substantially greater. The educational institution may accomplish its educational and research goals and experiment with and improve human service delivery. Other benefits could include more realistic cost allocation, less confusion about objectives, and a better opportunity to determine whether objectives are accomplished or not.

If there are to be several models of human service delivery, then there should be exposure to more than one model during training. For the time being, the integrated comprehensive mental illness service model currently known as the community mental health center is probably the best. This system consists of comprehensive mental illness treatment services integrated into a single system that has the responsibility for a given population and allows no rejection or export of a patient to other systems. This system should become the major site of training.

Training should also occur in the health care corporation, the health maintenance organization, and the educational, legal, and social service systems. In addition to direct service responsibility for individuals, small groups, and families, the trainee should receive supervised training in consulting about individual problems, classes of problems, agency functioning, administrative functioning, and budget. He should have the opportunity to sharpen his skills as a teacher so that he will be prepared to teach and to learn from a variety of other professionals and the public. More emphasis should be placed on administrative training, individual service, and the evaluation of the services of partial and whole systems. Only with this variety of learning opportunities will the trainee be ready for the complicated uncertainty that lies ahead.

A few predictions may be in order:

1. Treatment of individuals, small groups, and families will continue to be the psychiatrist's major contribution.

2. It is his understanding, his analysis, and his capacity to change human behavior that will support these activities.

3. In the future less time will be spent in direct treatment and more in consulting, supervising, and educating those who will engage in direct treatment.

4. Some of these people will be other mental illness technicians and professionals, but many service deliverers will be in other human service systems.

5. One of these other human service systems with which the psychiatrist will be deeply involved will be the health care corporation or the health maintenance organization.

6. If services for the mentally ill or the emotionally maladaptive are included in a national health and illness insurance benefit package, this change in financing, probably accompanied by changes in the organization of services, will profoundly affect the site and the type of the psychiatrist's work.

7. Involvement with educational, legal, and social services will be more frequent and more intense for most psychiatrists in the future. Many psychiatrists will be involved to some degree, and a few psychiatrists will be profoundly involved.

Our task, then, is to prepare our trainees in educational programs that encourage their participation in and learning about the more likely, more common, and more effective human service systems. They also must be flexible enough to alter their activities and sites of practice with changes in human service organization and financing.

REFERENCES

1. Carnegie Commission on Higher Education: Higher Education and the Nation's Health Policies for Medical and Dental Education: A Special Report and Recommendations. New York, McGraw-Hill, 1970
2. Report of a Special Committee on the Provision of Health Services. Chicago, American Hospital Association, 1970
3. Greenburg IG, Rodbury ML: The role of prepaid group practice in relieving the medical care crisis. Harvard Law Review 84:887–1001, 1971
4. Avnet HH: Psychiatric insurance—ten years later. Am J Psychiatry 126:667–674, 1969
5. Burnell GM: Financing mental health care: an appraisal of various models. Arch Gen Psychiatry 25:49–55, 1971
6. Scheidemandel P, Kanno CK, Glasscote RM: Health Insurance for Mental Illness. Washington, DC, APA-NAMH Joint Information Service, 1968
7. Woodlawn Organization: Woodlawn's Model Cities Plan: A Demonstration of Citizen Responsibility. Northbrook, Ill, Whitehall, 1970
8. Daniels R, Margolis P: The integration of community psychiatry training in a traditional psychiatric residency. Ment Hyg 49:17–26, 1965
9. Group for the Advancement of Psychiatry: Education for Community Psychiatry, Report No 64. New York, GAP, 1967

Answers to Questions of the Month

Page 1231. Question 1: C; Question 2: A.

On the Stresses of Community Psychiatry, and Helping Residents To Survive Them

BY ANDREW P. MORRISON, M.D., MILES F. SHORE, M.D., AND JERALD GROBMAN, M.D.

The authors underscore the major themes that challenge the resident who moves into community work from his initial experience as an individual therapist. The resident must be able to change, especially in terms of his own role expectations, to expand his repertoire of professional techniques, and to move from his former relatively passive stance to a new role in which he becomes more active. The supervisor should be ready to guide the resident in his work and be sensitive to his anxieties.

WITH THE COMMUNITY psychiatry movement of the 1960s, the relationship between service commitment and training orientation in psychiatric centers has come under scrutiny. If community psychiatry is to offer a major new theoretical model, with the community mental health center as its instrument, how can psychiatric training centers with a traditional viewpoint adapt to the demands of this movement and train potential leaders in the techniques required by community work? Early there developed schisms between the community psychiatrist and the psychoanalyst, and between intrapsychically and socially oriented factions (among other competing groups). More recently, however, several departments have moved toward integrating community concepts and experiences into general psychiatric training in an attempt to break down the barriers between community mental health and the rest of psychiatry (1–5).

The program from which the present observations were made is still evolving within a department that aims at reducing the polarization between community-oriented and psychoanalytically oriented psychiatry. The Tufts Mental Health Center is part of the Massachusetts system of community mental health centers; it consists of an affiliation of 17 agencies already existing in the South Boston-North Dorchester communities. At the same time it is an integral part of the training activities of the Tufts Department of Psychiatry, a dynamically oriented training center of Tufts Medical School and the New England Medical Center.

Some of the problems that psychiatric residents encounter as they move from the protection and status of the consulting room into the activity-oriented marketplace of the community will be considered here.

This paper is based on a panel discussion at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

The authors are with the Department of Psychiatry, Tufts University School of Medicine, Boston, Mass., where Dr. Morrison is Assistant Professor, Dr. Shore is Professor and Associate Dean for Community Affairs, and Dr. Grobman is Assistant Clinical Professor. Address reprint requests to Dr. Morrison, Mental Health Unit, 260 Tremont St., Boston, Mass. 02116.

THE NEED FOR TRAINING IN COMMUNITY PSYCHIATRY

From an institutional point of view, ideological values and funding necessities both support a shift toward delivery of mental health services at the neighborhood level. In order to prepare staff to work in these new programs, training in community mental health is becoming a significant part of residency training across the country; thus there is increasing emphasis upon crisis intervention, brief psychotherapy, outreach programs, aftercare, home visits, and even community organization and political action.

Also, the demands and needs of students entering residency training are shifting. In general, medical students during the late 60s and early 70s grew up in an atmosphere of activism, social commitment, and idealism that was not experienced by those of us who came before. A major shift in the professional goals of residents across the country has occurred, moving from an emphasis on exclusively psychotherapeutic private practice to the inclusion of more active, community-oriented roles. Part of this shift has led to demands by individual residents for more autonomy in determining the course of their training. Struggles between residents and their therapy supervisors reflect in part a desire to move out from under the thumb of their teachers and to become more actively involved in the community surrounding the training center. This shift, then, is part of a greater interest in and demand for training in the techniques of community psychiatry from some residents. Other residents, however, are anxious and resist deep community involvement.

PROBLEMS ENCOUNTERED IN COMMUNITY INVOLVEMENT WITHIN A GENERAL RESIDENCY PROGRAM

The problems enumerated in the following sections refer specifically to psychiatric residents, but obviously the same stresses may also apply to other mental health professionals and workers. These problems will be formulated in terms of specific anxiety-provoking stimuli and occasional responses to them that may be determined by the character styles of the residents themselves. The "culture shock" encountered from working in a community setting leads not infrequently to regressive trends, while

at other times it merely reinforces the disinclination of some residents to participate in community mental health. Other residents, of course, readily accept the challenges of community psychiatry.

1. From the Safety of the Office to the Dangers of the Community

In most training programs the resident is introduced to the central task of individual psychotherapy in a quiet office. In general, this office is his "turf," a haven for him alone to explore the intricacies of a patient's inner life. Here is seclusion, a place in which to conceptualize and feel, a potential retreat from the demands of patients, supervisors, and administrators.

Upon entering the community, the resident is stripped of this haven and must see people in busy, public, uncomfortable surroundings—the open marketplace. The setting is no longer of his choosing but is "theirs"—the alien turf of the community, where he is a guest. No longer can the resident sit back and wait for his patient to knock at his office door. Instead, he must initiate contact with people, in their domain, and with unclear goals. This change is, we believe, one of the important and underrecognized anxieties and sources of alienation in beginning community work (6).

These settings may include the large state hospital with its barren wards and disturbing inmates, the living room in home visits made to the families of patients, street consultations with adolescents and gangs, discussions with community leaders in cars while driving to a meeting, etc. This experience, it seems to us, leads not infrequently to a projection of the resident's own hostility at being ejected from his safe office. In this projection the responsibility is shifted from the resident's feelings on finding himself in an alien setting to questions of "treatability" of the patient. It is not the fact that the resident is frightened to be in the living room of a lower-class home that makes it difficult for him to treat patients, but rather that the patient is too sick or "too primitive."

2. From Receptivity to Activity

There are several facets to this particular point. Not only is the resident stripped of the protection of the office, but the comfort of having a patient request help is also gone. Much of community psychiatry is involved not with patients but with populations at risk, consumers, and ordinary citizens. To a certain degree, beginning residents learn to define themselves in terms of their role as "not patient" or helper, and for this self-definition the presence of a patient is essential. When this role does not apply, as is the case in much community work, psychiatric residents are confronted with a role diffusion of their own. Also, patients whom the resident is asked to see may differ sharply from those seen in clinics or on inpatient services. He may be confronted with a wildly aggressive family; the whole unit may be defined as the patient. The "patient" may be a dissatisfied group of community residents demonstrating for better health care.

These are situations with which the supervisor, to whom the resident turns in fright, may himself be unfamiliar. The supervisor can provide support, but the resident himself must frequently muddle through the situation as best he can, relying on his own judgment and developing expertise as he goes along. The need for self-reliance provokes considerable anxiety in the beginning resident, but it may also help him free himself from the infantilizing quality of supervisory relationships. The resident may choose to respond to the patient in a way other than as therapist. He may find a conflict between the role of clinician and consultant and may choose to help other workers serve as primary care givers. This role of consultant is new to the beginning psychotherapist.

Related to the switch in orientations necessitated by community psychiatric work is the matter of professional identity. There is frequently a conflict between seeing oneself as a screen reflecting the patient's projections and using oneself as a reactive person interacting with other real people in the community. As a function of supervision that necessarily teaches beginning residents to be more objective, scientific, and not quite so "giving" to their patients as they would ordinarily be, they learn a professional persona that is detached and aloof from patients. The neophyte resident may become like the familiar caricature of a psychiatrist, who responds to questions with more questions rather than with appropriate answers.

In contrast, the resident entering the community must learn to use his psychiatric skills with a persona that is more like ordinary social behavior. He is called upon to be a "regular guy" who meets agency staff and consumers openly and with respect. Can he be a real person and at the same time maintain his identity as a psychiatrist? The community experience can enhance a maturing process in which the resident learns to be real, available, and open in the formation of working alliances with community staff and patients alike.

However, this challenge can also cause turmoil in the beginning therapist. Not only is he confronted with the absence of the "patient" role, but his role definition as physician is undermined. He is demoted from the leadership position familiar in the hospital team, inherent in the primacy of the medical model. As psychiatric therapist, he determined the course of treatment and medication for his patients. In the community, however, he must interact as a peer with people from various professional backgrounds and frequently must take directions from a superior who lacks medical training—the agency director or community leader. This new set of role relationships is a blow to the resident's hard-earned status and self-esteem; residents' reactions to this loss vary widely, but it is a challenge to them all.

3. Role Conflicts in the Community

In this context we refer to the tendency, implied earlier, toward "either-or" thinking with regard to professional commitments. Because of the difficulty in learning intensive individual psychotherapy, many residents view psychoanalytic training as the pinnacle of their professional career. Others perceive the commitment to dy-

namic psychiatry of analytically oriented teachers and adopt what they consider to be an opposite, action-oriented community approach. These orientations tend to become polarized, with residents feeling that they have to choose between them. Thus if the resident sees himself heading toward an analytic career, he is sometimes anxious about feeling an interest in participating in community events. This problem can be minimized if a department's attitude is respectful of both orientations, emphasizing that they are not mutually exclusive. In the Tufts program, for instance, the fact that many of the psychiatrists working in community mental health are also psychoanalysts or analytic candidates demonstrates that one can at the same time be psychoanalytically oriented and work in the community.

However, related to the role conflicts that residents feel with regard to these orientations is the ever-present subtle devaluation of a community psychiatric orientation by therapists who are not at the same time involved in community work. Thus supervisors of individual therapy may ask, "What does the community psychiatrist really do?" or they may state, "I guess if one is uncomfortable sitting with patients and sharing their feelings, one can always do community work." This devaluation by people esteemed for their clinical abilities establishes professional priorities for the resident and makes it difficult for him to view community work with the same commitment as his more traditional therapeutic endeavors.

4. The Lack of Structure

With regard to time to be spent in the community, the work task to be established, and the identity of consumers with whom to interact, the resident is confronted with a lack of structure and defined expectations very different from his experience in doing psychotherapy. In contrast to the office appointments at a set hour, the resident may be asked to enter a neighborhood, contact agencies and find useful ways to interact with them, and meet people at unspecified times. The consumers do not have set expectations of the resident, and relationships must develop out of mutual exploration and discussion to establish shared goals. The resident cannot turn to his supervisor to be told what he should do, for frequently it is not clear which intervention or approach is the most effective for a given community situation. As an example of this turmoil and lack of structure, one resident entered a tumultuous situation in an agency just at the time that a generalized staff rebellion against the agency leader was in process. There was tremendous anger and confusion among the staff of the agency, and the resident was pulled in all directions to take a stand on his loyalties. In supervision, he confided that he did not even know what his task in the agency was supposed to be, let alone which groups he was to align himself with.

This chaos offers the opportunity for a real mastering experience, in which the resident can attempt to structure and understand both his task and his role within the agency. Intellectualization and other organizing defenses can be used in the mastery of an unstructured situation. On the other hand, some residents respond to the lack of structure by withdrawal and avoidance, retreating to a setting in which they feel more comfortable. Residents tend to reestablish well-integrated activities in alien surroundings in an attempt to bring familiarity to their task. An example of this tendency is a resident who elects to evaluate and treat patients at the new setting or agency. He might alter the therapeutic modalities that he offers (e.g., beginning to do brief psychotherapy), but it is psychotherapy nonetheless.

5. Community Rejection and Apathy

A major source of anxiety is the not infrequent response of disinterest and/or open hostility of community groups when the resident comes to offer his services. Used to gratitude, deference, or at least respect from his patients, the resident frequently is faced with angry, demanding citizens who criticize him or his profession for ignoring their needs or shun him for representing a discipline that frightens or alarms them. Such a response strikes a blow at professional pride and is the source of the anger and withdrawal of many residents in the community. An example of this response occurred when one resident, with the selfless feeling that he was offering his services to the poor, was interviewed by a citizens' committee on professional hiring for a ghetto health project where he wished to work for one day a week. The resident's motivations were challenged, he was called a racist and a do-gooder, and the committee finally rejected him for work in its center.

In our experience, some residents respond to such hostility in the community by recoiling with the shock of injured pride—the feeling of "Don't they realize that I am here to help them?" The resident may become angry and resentful in turn, either intellectualizing his experience (sometimes in a condescending manner) or withdrawing to avoid repetition of the situation. This anger is frequently a response to his being deposed from a position of control and relegated to being just another team member.

One example of the response to apathy is that of a resident who attempted to establish mental health consultation with the faculty and staff of a local high school, but who was perpetually confronted with excuses, unreturned telephone calls, failure of some faculty and staff to show up for scheduled meetings, etc. Certainly this experience is common to any worker actively engaged in trying to establish a mental health program. The response pattern includes that of injured self-esteem. However, rather than the anger with which many residents respond to community hostility, in the case of apathy one frequent response is that of depression and withdrawal. The resident wonders what he is doing wrong, why he is not being accepted for what he has to offer. He experiences considerable self-doubt and, occasionally, the depression that can accompany such a drop in self-esteem.

6. Excessive Expectations

In this last source of anxiety, residents initially place an excessively high demand on themselves to produce meaningful change. They may hope to restructure an

agency, overhaul society, or even change educational systems, as well as providing mental health aid to citizens. One resident, for instance, began to meet with a group of teachers in a local parochial school. Not only did he hope to teach them techniques of helping their students, but he also wanted to impart concepts of family dynamics and progressive teaching methods. Obviously his goals were unrealistic; it did not take long for the teachers to set him straight, since attendance quickly dwindled.

In attempting to meet these excessive expectations, the resident is frequently shocked by the limited change he can effect. He may intellectualize his distress at falling short of his own expectations, but he usually becomes anxious, and having failed to meet his own goals, he withdraws from the field.

HELPFUL HINTS FOR EFFECTIVE SURVIVAL

Recognizing that these stresses are inevitable and can never be totally eliminated, but must be weathered and gone through as part of professional development, we turn now to considerations of what can be helpful to the residents in mastering them. These suggestions will not be dramatically new to supervisors of psychiatric residents, and it will be seen that in many ways the supervisory task is similar to that of clinical supervision for new therapists. In fact, it is the familiarity of this supervisory relationship that gives the instructor a toehold in helping the resident to master his anxiety in this new professional endeavor.

Structuring

The supervisor must realize that the resident has very few guidelines or preconceptions of what his task in the community should be. He should thus be encouraged and assisted in defining one or more specific tasks with regard to agencies or a segment of the community with which he is going to interact. In order to assist the resident in doing this, of course, the supervisor must be familiar with the scope and tasks of community psychiatry and the range of possibilities open to the resident. The supervisor must know the community in order to be realistic in this task.

The process of structuring should be a mutually thoughtful exploration of possibilities, and the resident's own preference, fears, and feelings about his limitations should be fully considered in arriving at a project for his community work. Also, the need of the community or agency and the service commitments of the mental health program must be accounted for in helping the resident to define and structure his own task. At the Tufts Mental Health Center we have found that an important ingredient of the community experience, after the resident has had time to explore the range of options open to him, has been his own participation in structuring his work.

Conceptualizing

This relates very closely to the structuring factor just discussed. Here, we help the residents to step back from their immediate community experience, to look at the various issues in the task being required of them, and to formulate their plans, much as a supervisor helps a therapist to formulate his patient's needs and treatment goals. Basically, we refer here to utilization of mature intellectual skills to master a potentially chaotic experience. For the past two years at the Tufts Mental Health Center we have offered an introductory seminar for residents prior to their community experience, covering such areas as crisis intervention, brief psychotherapy, mental health consultation, and home visiting.

Support

The instructor of the beginning resident in community mental health must be aware of the stresses that the work involves (enumerated earlier) and willing to intervene supportively to share his trainee's anxieties. Of course, this is also true of clinical supervision, but the diffuseness of the task and the fact that the supervisor will not always have dealt with similar community situations himself makes the emphasis somewhat different. On the other hand, as in the experience from psychotherapy, some anxiety is necessary in order to motivate growth and change.

This inherent dilemma requires sensitivity to the resident's potential for being overwhelmed by anxiety and the supervisor's attention to cues that this may be occurring. Supervisors should make themselves available for night consultations to their residents, since emergencies may arise in the community at any hour. The instructor must also empathize with the resident's anxiety in situations that might normally seem trivial, e.g., meeting with a group of angry adolescents, approaching a meeting with a school principal to set up consultation with teachers, etc. The supervisor must be willing to switch into a clinical framework when emergency cases arise in the community and be able to share his own confusion or lack of knowledge when this is indicated.

The supportive function, then, represents a willingness to accept the resident's confusion in his new task, to provide a model of open humanness that he can emulate, and to share responsibility appropriately. This may help the resident to decrease his excessive expectations and hence to modify his guilt.

Psychiatric Commitment to Principles of Community Mental Health

In order to help the resident master his stresses in community work, the staff supervisor *must* be respectful of the community experience. Very often, as noted earlier, there is an unwritten message in analytically oriented departments of psychiatry relegating the community psychiatric work to second- or third-order importance. If the supervisor is unable to oppose such downgrading, how can the resident do otherwise? Thus a department committed to training in community mental health must also value community activities. The supervisor in community psychiatry must be able to help the resident to place in perspective some of the professional negativism to which he will be exposed, and ultimately—if community training is to be effective—there must be a cadre of flexible

staff members who serve as role models of equal status to teachers committed exclusively to intensive individual psychotherapy.

SUMMARY AND CONCLUSIONS

We have not attempted to present the ultimate word on how to help residents survive their community psychiatry experience. Rather, we have tried to underscore the major themes that challenge the resident who moves into community work from his initial experience as an individual therapist. We have presented these problems from the viewpoint of the resident and have related some of the more frequent anxiety-provoking stimuli to typical responses in terms of character styles of the residents.

We have an obligation to supervise and support the resident as he meets the challenge of community mental health, and in the process we are asking that same resident to *grow* as a mental health professional. In fact, we are asking the resident to *change*, especially in terms of his own role expectations. As the therapist requests and stimulates change from his patient, so too must training in community mental health require that the resident expand his repertoire of professional techniques. We ask that he be able to move out of the newly learned, relatively passive stance of the psychotherapist waiting in his office for a patient who requests help to a new role in which he becomes more active, involved in change, reaching out as an advocate of programs, techniques, and activities.

In effect, we are often asking him to add some of the skills of the salesman in presenting helping techniques to the consumer, who may not know of the mental health professional's skills or abilities (7). He must be willing to meet the challenges of lack of interest and resistance that he will find in the community and to take on what may be for him the new role of teacher. We ask him to step out of a role that emphasizes patienthood and the medical model and to interact as colleague, student, teacher, and even adversary. Finally, he must be willing and able not only to use the professional, distancing skills that he has learned in the initial experience with psychotherapy, but to integrate into a comfortable style personal, open skills of human relations that he has practiced in other settings since childhood.

REFERENCES

1. Pattison EM: Residency training issues in community psychiatry. Am J Psychiatry 128:1097–1102, 1972
2. Hammett VBO, Bodarsky CJ, Fink PJ: An integrated department of psychiatry/community mental health program: one model. Am J Psychiatry 127:1161–1165, 1971
3. Fink PJ, Newman R: An integrated psychodynamic community residency. Presented at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex, May 1–5, 1972
4. Borowitz GH, Hirsch JG, Puntil JE, et al: Residency training in community mental health. Presented at the 125th annual meeting of the American Psychiatric Association, Dallas, Tex, May 1–5, 1972
5. Scherl DJ: Training for community psychiatry in the general psychiatric residency. Massachusetts Journal of Mental Health 1:16–23, 1970
6. Ad Hoc Report Committee, Psychiatric Service, Health Services Coordinating Committee, Resurrection City: Psychiatric services to a sustained social protest campaign: an on-site, walk-in clinic at Resurrection City. Am J Psychiatry 125:1543–1551, 1969
7. Morrison AP: Mental health consultation and the marketplace. Adelphi, Md, Mental Health Study Center, National Institute of Mental Health, April 1969 (unpublished paper)

References for Questions of the Month

Pages 1231 and 1236.

Question 1: Klopfer B, Ainsworth MP, Klopfer WG, et al: Developments in the Rorschach Technique, vol 1. Yonkers on Hudson, NY, World Book Co, 1954, p 563

Question 2: Rainer JD: Genetics and psychiatry, in Comprehensive Textbook of Psychiatry. Edited by Freedman AM, Kaplan HI. Baltimore, Williams & Wilkins, 1967, p 41

Addicted Viet Nam Veterans: A Comparison of Self-Referred and System-Referred Samples

BY EDGAR P. NACE, M.D., SP5 ANDREW L. MEYERS, USA, AND JOSEPH M. ROTHBERG, PH.D.

The authors report that addicts who volunteered for an Army heroin treatment program differed from those who were detected by urine screening in that they had displayed a greater degree of antisocial behavior in civilian life and had more frequent psychiatric contacts in the service as well as a more extensive history of drug use. The finding that drug use is less frequent during the earliest months of military training than during both the preceding civilian months and the later phases of military duty suggests that recognition and intervention during the early months of military training may be the chief means of primary prevention.

BY 1970 PUBLIC ATTENTION had been drawn to the fact that an epidemic of heroin addiction was unfolding among American military personnel serving in the Republic of Viet Nam (1–3). The history of this epidemic and the factors involved in the spread of heroin in Viet Nam have recently been described (4). Prominent among the factors was a readily available supply of inexpensive highly purified heroin and a social network among peers that supported heroin use (5).

Before July 1971, any attempt to study addicted Viet Nam veterans was hindered by the fact that only those who sought help were available for research purposes. By July 1971, the U.S. Army had initiated a urine-testing program to detect heroin users among soldiers leaving Viet Nam. This program made available for research heroin addicts who had not voluntarily sought help for their addiction and who would possibly not have been identified otherwise. An opportunity was therefore available to investigate possible differences between two groups of addicted Viet Nam veterans: one group who voluntarily sought help from a medical facility in the United States for a problem related to addiction before the onset of the urine-testing program (henceforth called the self-referred group) and a second group who had not voluntarily sought medical help for narcotic addiction but were detected and confirmed as heroin users by the obligatory urine-testing program as they left Viet Nam between August and November 1971 (henceforth called the system-referred group). The members of both groups became addicted to heroin while serving in Viet Nam and had no prior history of addiction.

This paper describes the differences between these two groups of addicts and provides data suggesting that the early phases of military training may be a useful focus for drug abuse intervention efforts.

METHOD

Between December 1970 and November 1971, we screened more than 100 men who were active-duty enlisted U.S. Army personnel by means of interviews and psychological tests given at mental hygiene facilities of four different Army posts in the United States.

The criteria for inclusion in this study were as follows: 1) the subject had to be an active-duty enlisted man who was being seen in a mental hygiene facility for reasons related to drug abuse, 2) he had to be available to participate in the interview and testing procedures during the time the interviewers were at the clinics (of those who met the above criteria, fewer than ten percent refused to participate), and 3) he had to have become addicted while in Viet Nam.

Of the 36 men who met the three criteria, 18 were self-referred and 18 were system-referred. Each soldier was interviewed individually in a semistructured manner for one to one and one-half hours; he spent additional time completing paper-and-pencil tests. It was emphasized that if he felt unable to answer certain questions, he was to indicate that this was so. This underlined our emphasis on accurate information and our preference for no information rather than false information.[1]

The responses to the questions about drug use were categorized into six classes of drugs (marijuana, hallucinogens, amphetamines, barbiturates, narcotics, and "other") and four levels of use: none, moderate (one to ten times per month), heavy (11–50 times per month), and intensive (more than 50 times per month).

The time of initial addiction was operationally defined

At the time this paper was written, the authors were with the Department of Psychiatry, Division of Neuropsychiatry, Walter Reed Army Institute of Research, Washington, D.C., where Dr. Nace was Research Psychiatrist, Specialist 5 Meyers was Social Work-Psychology Specialist, and Dr. Rothberg is Mathematician. Dr. Nace is now Director, Alcoholic Treatment Program, Institute of the Pennsylvania Hospital, 111 West 49th St., Philadelphia, Pa. 19139, and Assistant Professor of Clinical Psychiatry at the University of Pennsylvania.

[1] The validity of interview material obtained from addicted subjects has been demonstrated by Ball (6) and Stimson and Ogborne (7). During the early phases of our study we obtained from the military records validation data on five pieces of interview information for 31 subjects. Agreement between the records and the interview averaged 89.9 percent (range: 65 percent to 100 percent).

as the month in which the subject first reported using heroin three or more times a day. No subject was considered addicted unless he reported using heroin three or more times a day for several months or reported subsequent withdrawal symptoms.

RESULTS

The self-referred and system-referred groups were not significantly different in their employment history, demographic makeup, family background, medical history, or frequency of civilian psychiatric contacts (see table 1). The average age of the subjects at the time of their induction into the Army was 18.5 years for the self-referred group and 19.7 years for the system-referred group. Their average age at the time of their addiction was 19.6 for the self-referred group and 21.1 for the system-referred group. The average age of the self-referred group at the time of their first contact with the Mental Health Consultation Service was 20.4 and that of the system-referred group was 21.8. The average age of the self-referred group at the time of the interview was 20.9; that of the system-referred group was 21.8. The self-referred group had received an average of 10.7 years of education; the system-referred group, 10.8. By the time of the interview, the average length of service was 2.6 years for the self-referred group and 2.1 years for the system-referred group. Fifty percent of both groups were from level IV of the Hollingshead and Redlich socioeconomic scale. The ratio of blacks to whites was 3:15 in both groups and the ratio of single to married men was 15:3 in both groups. Twelve of the self-referred group and 14 of the system-referred group came from cities of more than 50,000 people. The ratio of draftees to enlisted men was 3:15 in both groups. The median rank of the self-referred group was E-3; that of the system-referred group was E-4.

TABLE 1

Medical, Family, Employment, and Behavioral Characteristics of Two Samples of Viet Nam Veterans

Characteristic	Number of Subjects	
	Self-Referred (N=18)	System-Referred (N=18)
Medical history—civilian		
Nonpsychiatric hospitalization	11	8
Psychiatric contacts (hospital or outpatient)	8	4
Medical history—military		
Nonpsychiatric hospitalization	12	8
Psychiatric contacts (hospital or outpatient)	12*	5*
History of antisocial behavior—civilian		
Delinquency	18**	12**
Crimes against property	15*	6*
Crimes against persons	4	0
Legal contacts (jail, probation, arrests, etc.)	17*	9*
History of antisocial behavior—military		
Delinquency	7	7
Crimes against property	6	1
Crimes against persons	2	0
Court martial	11	12
Article 15	15	14
Family history		
No parental loss before age six	15	15
No parental loss before age 16	9	14
Family history of alcoholism or addiction	8	7
Stable employment***	13	14

*Significant at $p<.05$, using the Fisher exact test.
**Significant at $p<.01$, using the Fisher exact test.
***Defined as employment for at least four years before the interview and including time spent in military service and time spent as a full-time student.

Differences Between Self-Referred and System-Referred Patients

An examination of antisocial behavior, military psychiatric contacts, and patterns of drug use does reveal differences between the two samples (see table 1):

Antisocial behavior. During civilian life the self-referred group had engaged in significantly more acts of delinquency (fighting, truancy, school suspensions, traffic violations) and crimes against property (burglary, auto theft, larceny, shoplifting). They were also arrested, jailed, or put on probation significantly more often than the system-referred group.

During their military service, both groups showed a marked drop in these indices of antisocial behavior, and there were no statistically significant differences between the two groups. Similarly, the number of subjects receiving military disciplinary action (nonjudicial punishment or court martial) did not differ between the two groups.

Psychiatric contacts. Compared with the system-referred group, a significantly greater ($p<.05$) number of the self-referred group contacted a mental hygiene facility while in the Army (see table 1). This calculation excludes the contact during which our interviews were conducted. In spite of extensive drug use, only one of the 36 subjects had contacted an Army mental hygiene facility before becoming addicted to heroin.

It is of interest to examine the length of time between the onset of addiction and contact with a treatment facility. When interviewed for this study, the self-referred group had been addicted for an average of 16 months while the system-referred group had been addicted for an average of nine months. Considering the time span from onset of addiction to initial psychiatric contact (not necessarily the contact during which our interviews were conducted), the self-referred group made initial contact with a treatment facility an average of nine months after becoming addicted and the system-referred group an average of eight months after becoming addicted. Therefore, the self-referred subjects were seen at a treatment facility almost as early in their addiction as the group detected by urinalysis.

Patterns of drug use. The most consistent difference

between these two groups lies in the more extensive history of drug use reported by the self-referred group. Although both groups are similar on demographic variables and both first became addicted while serving in Viet Nam, there were differences in their use of drugs before they entered the Army. These differences were maintained while they were in the Army, not only during the period before they were sent to Viet Nam, but during the Viet Nam tour as well.

The self-referred group began using illegal drugs (excluding alcohol) at an average age of 15.3 years, compared with 17.4 years for the system-referred group ($t=2.24$, $df=34$, $p<.05$); they first experimented with narcotics at an average age of 18.6 years, compared with 20.4 years for the system-referred group ($t=2.53$, $df=34$, $p<.02$).

A comparison was made of the extent of drug use by the two groups of addicted Viet Nam veterans.[2] Before entering the Army, the self-referred group had a significantly greater number of man-months of use in all categories except narcotics ($p<.01$) and had a significantly greater number of man-months of heavy use (more than ten times a month) in all categories except narcotics and "other" ($p<.01$). A rather marked difference in drug use between the two groups is therefore apparent before their entry into the Army.

There was a precipitous drop in drug use during the two-month period of basic combat training; no significant differences between the groups were found. No heavy use was reported during this phase of training except for a few subjects in both groups who smoked marijuana.

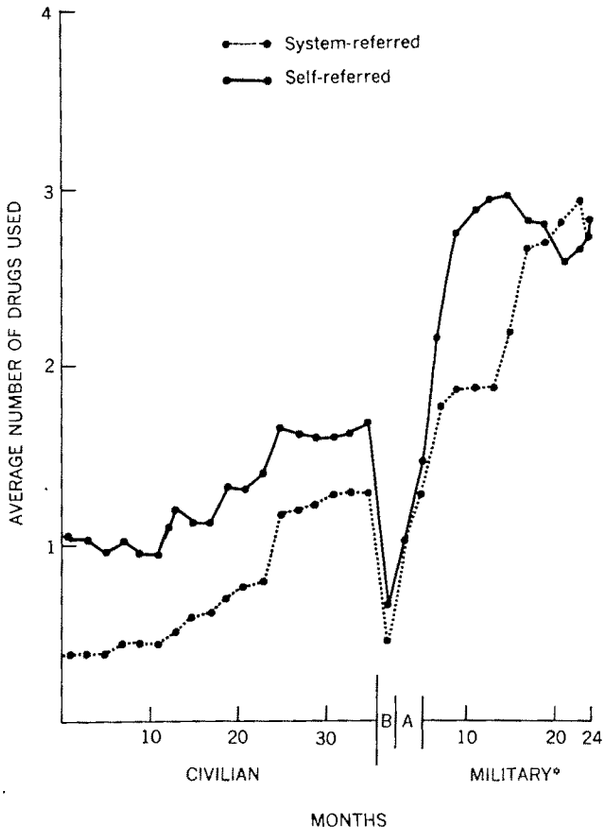
During advanced individual training, the three-month period following basic combat training, drug use began to increase for both groups; however, the self-referred group significantly exceeded the system-referred group only in the use of hallucinogens ($p<.05$).

In the period between advanced individual training and their assignment to Viet Nam, the self-referred group used marijuana, hallucinogens, and narcotics significantly more extensively ($p<.01$), but relatively little heavy drug use occurred. The differences between the two groups during this period are all the more noteworthy considering that the average waiting period for the self-referred group was one-third as long as that for the less drug-involved system-referred group.

Both groups first became addicted to heroin in Viet Nam. However, the self-referred group used marijuana and "other" drugs more often than the system-referred group ($p<.01$) and had a greater amount of heavy use of marijuana ($p<.02$) and of hallucinogens, barbiturates, and "other" drugs ($p<.01$).

Figure 1 compares the average number of drugs used by each of the two groups of addicted Viet Nam veterans during the 36 months before they entered the military and their first 24 months in the service. The figure illustrates the greater number of drugs used during civilian life by the self-referred group, the sudden drop in drug use by both groups upon entering the service, and the subsequent upswing above civilian levels after their advanced individual training. These differences between the two groups of addicted Viet Nam veterans involved both the number of drugs used and the extent of use of each drug.

FIGURE 1
Average Number of Drugs Used Before, During, and After Training Phases



* "B" refers to basic combat training and "A" to advanced individual training.

DISCUSSION

The data demonstrate that soldiers who became addicted in Viet Nam could be distinguished by the manner in which they came to the attention of mental hygiene facilities. This was true in spite of their similar demographic characteristics and the similar environments in which their addiction first occurred.

The variability that exists between and within the samples of addicts who have been studied emphasizes the necessity of avoiding stereotyped images of the addicted (8) and establishing a broad spectrum of treatment goals (9).

[2] The contingency chi square (with Yates' correction where appropriate) was used to express the differences in man-months of use for each class of drug. In all comparisons that were statistically significant, the direction of the difference was that of greater use by the self-referred group. Tabular material containing the chi-square values may be obtained from the authors.

It is likely that the self-referred group would require a more extended and concentrated medical-psychiatric treatment effort than the system-referred group. This supposition is based on the self-referred group's greater degree of maladaptive characterological problems, as evidenced by their history of antisocial behavior and previous psychiatric contacts. Further, the self-referred group's use of heroin had become chronic by the time they were interviewed, since they had been addicted for an average of 16 months by that time.

On the other hand, the fact that the self-referred group had come to the treatment facility voluntarily, relatively early after the onset of addiction, suggests that constructive intervention is at least a possibility with this population. Unfortunately, such an intervention was not accomplished for the subjects under consideration in this study. Nevertheless it is important for mental hygiene personnel to realize that they have the opportunity to intervene relatively early in the heroin-using "careers" of many soldiers.

The data suggest a focus for such intervention efforts. Figure 1 shows that during the earliest phases of military training (basic combat training and advanced individual training) a marked drop in drug use occurs. Given the highly structured and supervised environment of these training periods, it may be assumed that soldiers who use drugs during these phases are those with a relatively greater drug need and those who will be most willing to assume greater risks to obtain drugs. Such subjects are likely to be at high risk for eventual addiction.

Intervention with even the relatively small number of drug-using soldiers who might be known to medical personnel during basic combat training and advanced individual training would not be a trivial event. Even a few persons may spread the use of drugs to others through social relationships, as has been demonstrated by Hughes and colleagues (10). The drug user may serve as the originator of a drug distribution network among his peer group since procurement and distribution become more feasible, as well as more profitable, when greater numbers are involved. An attempt to intervene with these subjects during the early phases of their military training may have favorable epidemiological consequences, since their own drug use as well as their potential for spreading drug use to others would be restrained. The most effective form of intervention has not yet been determined, but the possibilities would include such techniques as community supervision like that in the California parole program (11), assignment to a special medical treatment facility (12), and the currently used individual and group counseling techniques. Or basic combat training and advanced individual training could be considered screening periods for drug abuse in which those who are detected as heroin users would be discharged from the service.

Whatever its nature, early intervention with a person who will almost certainly become a chronic drug user may prevent the development of a drug distribution network. If a treatment model is established as the intervention of choice, success is likely to be increased by providing treatment early in a setting that enhances the commitment of the client to the therapy. This alternative is preferable to that in which the accidentally detected heroin user grudgingly goes through the motions of participating in an obligatory treatment program.

REFERENCES

1. Extent of drug use and addiction in Armed Forces appears wider than Pentagon's statistics show. New York Times, June 8, 1970, section C, p 25
2. Alleged drug abuse in the Armed Services, hearings before the Committee on Armed Services, House of Representatives. Washington, DC, US Government Printing Office, 1971
3. Baker SL: Drug abuse in the United States Army. Bull NY Acad Med 47:541–549, 1971
4. Holloway HC: Epidemiology of heroin dependency among soldiers in Vietnam. Milit Med (in press)
5. Ingraham LH: "The Nam" and "the world": a description of heroin use by U.S. Army enlisted men serving in the Republic of Vietnam. Washington, DC, Department of Psychiatry, Walter Reed Army Institute of Research, 1973 (processed)
6. Ball JC: The reliability and validity of interview data obtained from 59 narcotic drug addicts. Am J Sociology 72:650–654, 1967
7. Stimson GV, Ogborne AC: Survey of addicts prescribed heroin at London clinics. Lancet 1:1163–1166, 1970
8. Davis WN: The treatment of drug addiction: some comparative observations. Br J Addict 65:227–235, 1970
9. Freedman AM: Toward a rational approach to the treatment of narcotic addiction: basic notions, in The Addictive States. Edited by Wikler A. Baltimore, Williams & Wilkins, 1968, pp 378–386
10. Hughes PH, Crawford MA, Barker NW: Developing an epidemiologic field team for drug dependence. Arch Gen Psychiatry 24:389–393, 1971
11. Kramer JC, Bass RA, Berecochea JE: Civil commitment for addicts: the California program. Am J Psychiatry 125:816–824, 1968
12. Colman AD: The Planned Environment in Psychiatric Treatment: A Manual for Ward Design. Springfield, Ill, Charles C Thomas, 1971

Popular Attitudes and Beliefs About Tranquilizers

BY DEAN I. MANHEIMER, M.A., SUSAN T. DAVIDSON, MITCHELL B. BALTER, PH.D., GLEN D. MELLINGER, PH.D., IRA H. CISIN, PH.D., AND HUGH J. PARRY, PH.D.

In a nationwide survey of the extent and nature of psychotherapeutic drug use, respondents were also questioned about their knowledge of tranquilizers and their attitudes toward the use of these drugs in general and in specific situations. The survey revealed surprising similarities of attitudes across demographic subgroups. Although respondents believed in the efficacy of tranquilizers and were willing to condone their use in some specific circumstances, they also had doubts about their long-term effects and about the morality of using them. Doubts about the morality of using tranquilizers were associated with traditional stoic values.

THE RISING POPULARITY of psychotherapeutic drugs [1] since the introduction of tranquilizers in the mid-1950s has resulted in much public attention and concern about the amounts of these drugs people are using and the vast numbers of people who are using them. Quite apart from the medical issues involved, some social commentators fear that widespread use of these mood-changing drugs is indicative of major undesirable changes in the American character. Some see increased drug use as a cause, others as a consequence, of a general moral decline. Many critics believe that the use of psychotherapeutic drugs indicates weakness and undermines the values of self-reliance, self-control, and will power in coping with problems. There is a related belief that the use of medications that provide symptomatic relief necessarily reduces one's motivation or ability to deal with problems directly.

Much of the discussion about drug-taking practices and the characteristics of users has occurred in the absence of adequate data. Reliable answers are needed for the following questions: How many people are using mood-changing drugs? What are the characteristics of the drug users? How often and for how long are the drugs being used? How prevalent are the emotional and somatic disorders for which use is indicated? How severely distressed are those who obtain drug treatment? What are the popular attitudes and beliefs regarding use of psychotherapeutic drugs? How are these attitudes related to drug-use experience and to more general beliefs and values?

This article will focus on attitudes and beliefs about drug use. Two companion papers report on the prevalence of drug use, characteristics of users, and the prevalence and severity of symptoms for which psychotherapeutic drugs are being used (1, 2). The data reported in all three papers were collected as part of a nationwide survey on the extent and nature of psychotherapeutic drug use in the United States. Taken together, the three papers should provide a basis for a more rational evaluation of the personal and social implications of this drug use than has been possible until now.

METHOD

The nationwide survey of drug use on which this paper

Mr. Manheimer is Director, Ms. Davidson is Research Analyst, and Dr. Mellinger is Associate Director of the Institute for Research in Social Behavior, Berkeley, Calif. Dr. Balter is Chief, Special Studies Section, Psychopharmacology Research Branch, National Institute of Mental Health, Rockville, Md. Dr. Cisin is Director and Dr. Parry is Associate Director of the Social Research Group, George Washington University, Washington, D.C. Address reprint requests to Mr. Manheimer at P.O. Box 5007, Berkeley, Calif. 94715.

This work was supported by Public Health Service grants MH-12590 and MH-12591 from the National Institute of Mental Health.

[1] By "psychotherapeutic drugs" we mean mood-changing drugs that are used as medicines to alleviate psychic distress or as adjunctive treatment of physical disorders and that are typically acquired through a doctor's prescription.

Topical Papers is a new section of the Journal. *The papers in this section are grouped around a given topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.*

is based is the most recent in a series of surveys carried out jointly by the Institute for Research in Social Behavior, Berkeley, Calif., and the Social Research Group of George Washington University, Washington, D.C., with the support and close collaboration of the Psychopharmacology Research Branch of NIMH.

The data for the survey were collected in late 1970 and early 1971. Respondents were selected by rigorous probability sampling methods to ensure a representative cross section of noninstitutionalized American adults. The data were obtained in personal interviews with 2,552 persons from 18 to 74 years of age living in the contiguous United States. These 2,552 persons represented more than 85 percent of the original sample.

The interviews ranged in length from 60 to 90 minutes. In addition to a detailed set of questions about the use of psychotherapeutic drugs, questions were asked about the respondent's general state of health, various psychic and somatic symptoms to which he might be subject, the occurrence of major life crises that might have resulted in emotional distress, and knowledge about and attitudes toward tranquilizers.

The first question asked concerning drugs was "What does the term 'tranquilizer' mean to you—that is, just what would you say a tranquilizer drug or pill is?" After a series of questions about the use of psychotherapeutic drugs, we asked questions designed to assess attitudes and beliefs about such use. One series of questions on attitude dealt only with tranquilizers—their effectiveness, the morality of using them, their impact on mood and behavior, and the short- and long-term physical effects and risks associated with their use. We chose to ask about tranquilizers because they are the most frequently used and most highly publicized psychotherapeutic drugs.

In another series of questions employing a different approach, respondents were asked whether or not they would condone the use of drugs in several concrete problem situations with varying social contexts and degrees of distress. Parallel sets of questions were asked concerning use of drugs to alleviate anxiety and depression. Our intent was to determine general levels of permissiveness with respect to drug use in different social contexts and under varying degrees of impairment.

KNOWLEDGE ABOUT TRANQUILIZERS

Most people do know what effect a tranquilizer has. When asked to describe the meaning of the word "tranquilizer," almost 70 percent of the respondents gave definitions that explicitly mentioned a tranquilizer's desired effect—to calm, relax, or relieve tension or anxiety. Only 11 percent said they did not know what a tranquilizer was,[2] and another three percent gave definitions that were clearly incorrect. The remainder responded either with value judgments or vague descriptions that applied as well to other drugs as to tranquilizers—e.g., "pill for mental patients," "makes you feel better," "it's habit forming," "makes you sleep," "they're bad for you . . . shouldn't take them."

Not surprisingly, knowledge about tranquilizers varied with age and education. For example, 23 percent of the respondents aged 60 to 74 said they did not know what a tranquilizer was, in contrast to four percent of the 18- to 29-year-olds. And although 22 percent of those with less than a high school education said they were unable to define a tranquilizer, the corresponding number among college-educated respondents was only three percent.

All data reported in the remainder of this paper exclude respondents who said they were unable to define a tranquilizer.

ATTITUDES AND BELIEFS ABOUT TRANQUILIZERS

Respondents were asked whether they agreed or disagreed with a wide range of statements of attitudes and beliefs about minor tranquilizers. These statements were presented to respondents with the following instructions:

> Now I'm going to give you a list of statements people have made about tranquilizers—that is, pills such as Miltown, Equanil, and Librium that can be used to calm you down or keep you from getting nervous or upset. As you read each statement, please . . . tell whether you agree strongly, agree, disagree, or disagree strongly.

The percentages of respondents agreeing and disagreeing with the various statements are shown in table 1. Items that reflect similar issues are grouped under the same topic heading. Note that these data show only the extent to which people subscribe to the statements and do not necessarily reflect their degree of concern about the issues.

Most respondents believed that tranquilizers are effective calming agents. However, substantial majorities agreed that they don't really cure anything and may even prevent people from working out their problems. The almost 90 percent of respondents who agreed that it is better to use will power to solve problems than it is to use tranquilizers and the sizable number who agreed that taking tranquilizers is a sign of weakness exemplify a stance that Klerman has aptly labeled "pharmacological Calvinism" (4) and suggest that there is considerable conservatism concerning the morality of using psychotherapeutic drugs.

Two items in table 1 deal with the question of control over behavior and mood. About two-thirds of our respondents agreed that tranquilizers can interfere with such control. Agreement with the first of these statements partly expresses the belief that the side effects of tranquilizers can impair mental alertness and physical performance. However, we think that both statements further reflect the belief that tranquilizers generally diminish one's drive, effectiveness, and sense of responsi-

[2] Knowledge about tranquilizers has increased considerably in the last ten years. In 1960, the Psychological Corporation found that 32 percent of the public surveyed could not define a tranquilizer when asked the identical question (3).

TABLE 1

*Percentages Agreeing and Disagreeing with Statements Reflecting General Attitudes and Beliefs About Tranquilizers (N = 2,241)**

Statement	Agree	Disagree	No Answer/ Don't Know
Efficacy			
Tranquilizers work very well to make a person more calm and relaxed.	74	20	6
Self-awareness and problem solving			
Tranquilizers don't really cure anything; they just cover up the real trouble.	69	25	5
Using tranquilizers just prevents people from working out their problems for themselves.	57	37	6
Self-reliance and strength of character			
It is better to use will power to solve problems than it is to use tranquilizers.	87	10	3
Taking tranquilizers is a sign of weakness.	40	55	5
Control and responsibility			
Tranquilizers cause people to lose some control over what they do.	61	31	7
Tranquilizers can change your mood so that you just don't care about anything.	66	28	6
Short-term side effects			
One big advantage of tranquilizers is that they *don't* make a person sleepy or groggy.	12	79	9
Tranquilizers often have bad side effects—such as making a person very sleepy or sick to the stomach.	73	18	9
Long-term adverse effects			
Long-term use of tranquilizers may cause real physical harm to your body.	80	14	6
One good thing about tranquilizers is that people do *not* get addicted to them.	18	74	9
Consumer concerns			
Tranquilizers often get on the market before they are thoroughly tested to be sure they are safe.	57	30	12
Tranquilizers are too new for doctors to know what harm they might do to a person in years to come.	39	52	9
Many doctors prescribe tranquilizers more than they should.	59	30	11

*"Agree" combines the answer categories of "agree" and "agree strongly" and "Disagree" combines "disagree" and "disagree strongly." In most cases the percentages for "agree strongly" and "disagree strongly" were quite small; the exceptions were "It is better to use will power than it is to use tranquilizers" (35 percent agreed strongly) and "Long-term use of tranquilizers may cause real physical harm to your body" (25 percent agreed strongly).

bility. Support for this latter interpretation can be found in the relatively high correlations between responses to these items and the more obviously moralistic ones, e.g., "Taking tranquilizers is a sign of weakness." One respondent's remark typifies this viewpoint: "I want to be in full control of myself, right or wrong; so I don't want some chemical to do something to my system over which I don't have control." Responses to the four items concerning the physical consequences associated with tranquilizer use show that most of our respondents thought that tranquilizers have undesirable side effects and may be physically harmful if used over a long period of time. Many respondents also felt that not enough care was exercised in screening and prescribing these drugs.

In general, it appears that Americans believe tranquilizers are effective but have serious doubts about the morality of using them and about their physical safety. Although these beliefs are by no means unanimous, the degree to which they are held is remarkably similar across the various subgroups for sex, age, education, income, and area of residence. The few clear-cut differences that we did find among demographic groups are shown in table 2. These are differences by educational level on two of the moral issues associated with tranquilizer use. Respondents with the least education were the most likely to agree that using tranquilizers indicates weakness of character and that their use prevents a person from solving his problems himself.

CONDONING DRUG USE

Another way of assessing views about the use of psychotherapeutic drugs is to examine the respondents' willingness to condone their use in a variety of practical circumstances. We described situations involving family or work in which a person might need or want to use such a drug and asked our respondents whether or not they approved of taking a drug in each situation. We further measured attitudes by comparing condoning of drug use for two types of distress—anxiety and depression—at various levels of behavioral impairment within the family and work situations.

Questions about using drugs for anxiety preceded those about using drugs for depression and were widely separated from them in the interview schedule because we wished to minimize bias in responses.[3] The preface to each question and the questions themselves are shown be-

[3] In one of the community studies conducted prior to the national survey, we tested the effect of order by asking half the sample the questions about drug use for anxiety first and the other half the questions about use for depression first. Order had a very small effect on responses. We feel confident that by widely separating these sets of questions in the national survey we have virtually eliminated this effect.

TABLE 2
Percentage Agreeing with Statements About the Morality of Tranquilizer Use According to Educational Level

Statement	Less than High School Graduate (N = 791)	High School Graduate (N = 738)	Some College (N = 405)	College Graduate (N = 305)
Using tranquilizers just prevents people from working out their problems for themselves.	62	58	54	44
Taking tranquilizers is a sign of weakness.	50	40	34	29

low (the alternate drug description is enclosed in parentheses). Notice that the emphasis was on the effects the drugs produce rather than on names of drug classes.

> Let's assume that someone has a supply of pills on hand that a doctor prescribed and said to take as needed. These pills calm you down or make you feel more relaxed (*or* These pills make you feel more energetic or alert, or lift your spirits). Just suppose that the person is trying to decide whether to take one in each of the following situations. Do you agree or disagree that it's all right to take a pill or medicine like this when someone:
>
> 1. is generally doing a good job at work but wants to be relaxed (*or* to have more energy) in order to be even more efficient and productive?
> 2. is upset and nervous (*or* is down in the dumps or has little energy) and not working as well as he should?
> 3. is so upset or nervous (*or* is so depressed or has so little energy) that he is not even able to go to work?
> 4. wants to relax (*or* wants more energy) in order to enjoy his family more than usual?
> 5. is nervous and upset (*or* is depressed) and can't get along with his family as well as usual?
> 6. is so upset and nervous (*or* is so depressed or has so little energy) that he is making life miserable for his family?

These situations differentiated among three levels of functioning: items 1 and 4 described drug use to enhance normal functioning; items 2 and 5 described use to offset a moderate deficit in functioning; and items 3 and 6 described use to offset a major deficit in functioning. Table 3 shows the percentages of respondents who condoned using the drug in each situation.

TABLE 3
Percentage Condoning Drug Use for Anxiety and Depression Under Various Conditions of Social Functioning (N = 2,241)

Condition	Drug for Anxiety	Drug for Depression
In work context		
1. To enhance normal functioning	13	8
2. To offset moderate deficit	55	38
3. To offset major deficit	64	50
In family context		
4. To enhance normal functioning	19	17
5. To offset moderate deficit	48	37
6. To offset major deficit	62	48

It is apparent from table 3 that the number of respondents approving of drug use increased with the severity of the impairment described. This finding is consistent for both types of distress and for both work and family settings. For example, when asked about use of a drug to calm a person down or make him feel more relaxed in the context of work, only 13 percent condoned use "to be even more efficient and productive," whereas the majority condoned use "when someone is upset and nervous and is not working as well as he should." This finding reflects the judgment that it is all right to take a drug to correct a significant deficit in ability to function in a vital life situation, but that it is definitely not all right to use a drug simply because a person wants to function better than he normally does.

Not apparent from table 3 is the fact that some respondents who approved of taking a drug when there is a mild difficulty in functioning did not agree to its use at the maximum level of distress described. Among those who sanctioned drug use for anxiety when there is moderate impairment in functioning at work, one-fifth disagreed to its use "when someone is so upset or nervous that he is not even able to go to work." These people frequently commented that anyone who is having such severe problems should be seeing a doctor or psychiatrist rather than simply taking a pill.

Although the extent to which use was sanctioned is roughly the same for both life contexts (family and work), people were more willing to condone the use of an anti-anxiety agent than they were to condone the use of an antidepressant. This is particularly evident in the situations involving difficulty in functioning. Why should this difference in attitude exist? We think it may reflect different social attitudes toward anxiety and depression.[4] We also suspect that, although we did not specifically name any drugs, the description of a pill to "make you feel more energetic or alert" conjured up a vision of

[4] We considered the possibility that the relative prevalence of anxiety and depression among respondents in our sample could partly account for this finding. This was not the case. Respondents who reported experiencing anxiety were no more likely to condone drug use for anxiety than for depression. Similarly, those who had experienced a variety of depressive symptoms were as likely to condone use for anxiety as they were for depression. Both groups were more likely to condone use of drugs for both types of distress than were respondents who had not experienced either type of distress.

TABLE 4
Percentage Condoning Drug Use for Anxiety in Work Context According to General Attitudes Toward Tranquilizers

Statement	Opinion*	Number	Condition—Work Context: To Offset Moderate Deficit	Condition—Work Context: To Offset Major Deficit
Tranquilizers work very well to make a person more calm and relaxed.	Agree	1,651	61	69
	Disagree	454	33	46
Using tranquilizers just prevents people from working out their problems for themselves.	Agree	1,264	45	57
	Disagree	840	70	75
Taking tranquilizers is a sign of weakness.	Agree	922	41	53
	Disagree	1,206	65	72
Tranquilizers cause people to lose some control over what they do.	Agree	1,370	47	58
	Disagree	698	71	76
Tranquilizers often have bad side effects—such as making a person very sleepy or sick to the stomach.	Agree	1,632	52	62
	Disagree	405	68	72
Long-term use of tranquilizers may cause real physical harm to your body.	Agree	1,770	52	62
	Disagree	331	70	73

*"Don't know" or "no answer" responses are omitted.

the notorious "pep pill."

The percentages did not vary much from those presented in table 3 when comparisons were made on the basis of such demographic variables as age or sex. The one exception was a comparison based on the region of the United States in which respondents lived. More westerners sanctioned the use of psychotherapeutic drugs than did residents of other areas of the United States. Although none of the differences was great, the gap between the West and the rest of the country was consistent for all six situations described. This parallels the higher rate of psychotherapeutic drug use reported for the West (1).

The extent to which condoning drug use was related to some of the beliefs about tranquilizers discussed earlier is shown in table 4. For ease of presentation, we have selected six items from table 1 to represent the issues of efficacy, morality, control over behavior and mood, and the short- and long-term physical effects associated with tranquilizer use. In table 4 (and in all subsequent tables that contain data concerning general attitudes and beliefs about tranquilizers) only these six items will be used.[5] It should be noted that although we show data only for work-related situations, the relationship was similar for family-related situations.

Respondents whose general attitudes toward tranquilizers were negative were less likely to condone the use of such drugs in specific situations than were those whose general attitudes were positive. However, even among respondents who were negatively disposed in general, the majority were willing to condone the use of tranquilizers when asked to make a judgment about a concrete situation. Even among those who equated tranquilizer use with personal weakness, over half condoned such use by someone who is so upset that he is not even able to go to work. No doubt this is partly explained by the fact that we asked our respondents to assume that the person described in each situation already had a supply of tranquilizers on hand that a doctor had prescribed to be used as needed. But we also think this seeming inconsistency between general attitudes and willingness to condone use in concrete situations exemplifies the actual conflicts many people experience with respect to the use of psychotherapeutic drugs.[6] On the one hand they believe that unpleasant side effects and physical dangers are associated with their use, that taking drugs of this type implies weakness, and that using them may prevent the solution of personal problems. On the other hand they believe that such drugs are effective in relieving emotional distress and apparently feel that their use is warranted in concrete situations in which important life activities or relationships are threatened.

It seems clear from table 4 that beliefs about the short- and long-term physical consequences of tranquilizer use are not very strongly related to willingness to condone use. An analysis of the joint effects of the six items shows that the issues of morality, behavioral consequences, and efficacy are more influential in the decision to condone use than are beliefs about negative physical consequences.[7]

[5] An examination of data not presented here revealed that the patterns shown for these six items are typical of the content area each represents. For example, the pattern for the item concerned with addiction is almost identical to that concerned with long-term use and harm to the body. We omitted items in the area of consumer concern because they were more concerned with social institutions than with intrinsic characteristics of tranquilizers or their users.

[6] Doubts about tranquilizers may also apply to drugs that are not psychotherapeutic, of course. Nevertheless, tranquilizers and other psychotherapeutic drugs probably cause greater conflict than do drugs that are considered "medicines" for primarily somatic complaints.

[7] At least this is so with respect to the practical situations we described. It is conceivable that the long-term safety of tranquilizer use would appear as an issue of first importance if we had asked our respondents to condone long-term use.

TABLE 5
Percentage Agreeing with Statements About Tranquilizers According to Score on the Stoicism-Traditionalism Index

Statement	Stoicism-Traditionalism Score				
	0–1 (N=156)	2–3 (N=797)	4 (N=595)	5 (N=480)	6 (N=213)
Tranquilizers work very well to make a person more calm and relaxed.	74	78	74	73	62
Using tranquilizers just prevents people from working out their problems for themselves.	43	51	60	61	70
Taking tranquilizers is a sign of weakness.	27	33	42	50	60
Tranquilizers cause people to lose some control over what they do.	50	56	63	69	71
Tranquilizers often have bad side effects—such as making a person very sleepy or sick to the stomach.	72	72	73	75	78
Long-term use of tranquilizers may cause real physical harm to your body.	72	79	82	82	81

ATTITUDES TOWARD TRANQUILIZERS AND VALUE ORIENTATIONS

In our investigation we also considered the question of whether attitudes toward tranquilizers stand in isolation or are related to larger value orientations or a broader social ethic—in particular, to values that reflect the "work, achieve, succeed, do not complain" orientation commonly associated with the Protestant ethic. To examine this dimension we constructed an index that we called "stoicism-traditionalism." The index items were contained in a questionnaire completed by respondents after the interview. There were four true-false items:

Even if a person has troubles there is no reason why he cannot keep up a cheerful front.
We should bear our troubles bravely and not complain.
There is something wrong with a person who is not willing to work hard.
I always follow the rule: "business before pleasure."

Each of these items was given a score of 1 if the respondent answered "true." The following six items were presented as statements people might like to make about themselves in looking back over their lives:

1. I have enjoyed life and had fun.
2. I have been loved.
3. I have always done my work to the best of my ability.
4. I have enjoyed the beautiful things in life.
5. I have made a lot of money.
6. I have lived a moral, respectable life.

The respondents were asked to indicate the importance of each by ranking it in relation to the other five. If items 3 and 6 were ranked within the first three, each was given a score of 1. The item scores were summed to produce an index score from 0 to 6.

The relationship between scores on the stoicism-traditionalism index and attitudes toward tranquilizers is shown in table 5. Agreement with the statement embodying the essence of pharmacological Calvinism—"Taking tranquilizers is a sign of weakness"—is strongly related to a high score on the stoicism-traditionalism index, whereas beliefs about physical risks are virtually unrelated. Note also the large percentage differences between the low and high scorers with regard to the statements concerning loss of control and interference with problem solving. We believe that these are further illustrations of the strong influence of moral values in matters concerning psychotherapeutic drug use. The relationship between these drug attitudes and general value orientations is fairly constant for all demographic groups. For example, even though older people tend to score higher on stoicism-traditionalism than do younger people, the relationship between traditional stoic values and the belief that tranquilizer use is a sign of weakness remains constant for the two groups.

ATTITUDES TOWARD TRANQUILIZERS AND MENTAL ILLNESS

We examined the relationship between attitudes toward the use of tranquilizers and attitudes toward mental illness on the assumption that views about the legitimacy of use might, in part, reflect attitudes about the legitimacy of psychic illness. To do this we used data from a large community study carried out in Contra Costa County—an area suburban to San Francisco—roughly 18 months before the national survey. In the Contra Costa study we included the following true-false item: "One of the main causes of mental illness is lack of moral strength or will." About 40 percent agreed with this statement, and those who agreed with it were more than twice as likely as others to agree that taking tranquilizers is a sign of weakness (the same general relationship held true for other items that were concerned with undesirable moral and behavioral consequences of tranquilizer use). Both of these beliefs were associated with lower educational attainment. Because the Contra Costa sample had on the whole a much higher level of education than

TABLE 6
Percentage Agreeing with Statements About Tranquilizers According to Personal Use of Prescription Psychotherapeutic Drugs

Statement	Tranquilizer Users* (N=652)	Nontranquilizer Users (N=386)	Nonusers of Psychotherapeutic Drugs (N=1,203)
Tranquilizers work very well to make a person more calm and relaxed.	85	79	67
Using tranquilizers just prevents people from working out their problems for themselves.	42	58	63
Taking tranquilizers is a sign of weakness.	30	38	46
Tranquilizers cause people to lose some control over what they do.	48	61	68
Tranquilizers often have bad side effects—such as making a person very sleepy or sick to the stomach.	68	72	76
Long-term use of tranquilizers may cause real physical harm to your body.	74	80	83

*Because a few respondents were unable to identify a drug they had used by name but could only describe the drug by its function, e.g., "a drug to calm my nerves," "tranquilizer" is here defined as a combined class of tranquilizers and sedatives. Of this group of users, 78 percent had used a named tranquilizer; 12 percent had used an unidentified sedative or tranquilizer in order to become calm. Only nine percent had used a sedative and not a tranquilizer, but of course some of these took the sedatives specifically for their calming action.

our national sample, it is reasonable to assume that in the national sample an even higher proportion consider mental illness a consequence of moral weakness and that the relationship between this attitude and beliefs about the morality of using tranquilizers is at least as strong. The proportion of respondents who agreed that taking tranquilizers is a sign of weakness was 30 percent in the Contra Costa sample and 40 percent in the national sample.

ATTITUDES TOWARD TRANQUILIZERS AND PERSONAL DRUG USE

Table 6 shows how beliefs about tranquilizers are related to personal experience with prescription psychotherapeutic drugs. Respondents are divided into three groups on the basis of lifetime experience with psychotherapeutic drugs: those who have used prescription tranquilizers (tranquilizer users), those who have used another prescription psychotherapeutic drug but not a tranquilizer (nontranquilizer users), and those who have never used any prescription psychotherapeutic drug.

Differences between prescription tranquilizer users and those who have never used a prescription psychotherapeutic drug are significant, except with respect to opinions on short-term side effects and long-term physical harm. Those who have used only prescription nontranquilizers view tranquilizers with less favor than do tranquilizer users but with more favor than nonusers.[8] The consistently intermediate position that users of nontranquilizing drugs have with respect to all items in table 6 suggests that attitudes and beliefs about tranquilizers do reflect more general beliefs about psychotherapeutic drugs.

It is apparent from table 6 that, even though differences between users and nonusers are pronounced, a large percentage of users also hold unfavorable opinions about tranquilizer use. These findings argue strongly that people are not being misled into believing that tranquilizers are a magic solution to their problems.

Although it is tempting to make inferences regarding the influence of attitudes on use and of use on attitude, we cannot properly do so. The attitude data and the use data were collected at the same time; thus there is no way we can determine whether particular attitudes and beliefs preceded or followed use of a psychotherapeutic drug. It is clear that beliefs can be influenced by experience. Studies of cognitive dissonance, in particular, suggest that, when beliefs and behavior are inconsistent, beliefs are likely to be reinterpreted to support the behavior (5). What hints we can coax from our data tend to support this finding, as well as the view that those with values and beliefs opposing the use of drugs are less likely than others to use them.

CONCLUSIONS

There is considerable evidence that Americans believe in the efficacy of psychotherapeutic drugs but have doubts about the virtue of using them. These doubts encompass immediate and long-term physical effects as well as potential moral and behavioral consequences, such as losing control over one's actions or a reduced sense of responsibility. In addition, many people feel that the use of drugs that simply alter a mood or emotional state may mask symptoms or reduce motivation to change, thus interfering with the solution of underlying problems. Others feel that such drug use is clearly a moral or characterological issue; this was reflected in the large proportion of people who agreed with the blunt

[8] Additional comparisons (not shown) between users of prescription psychotherapeutic drugs and users of over-the-counter varieties exhibited the same pattern. Those who had used over-the-counter drugs were more likely than those who had never used any psychotherapeutic drugs to have favorable attitudes toward tranquilizers and less likely than prescription nontranquilizer users to have favorable attitudes toward tranquilizers.

statement that taking tranquilizers is a sign of weakness.

Beliefs about psychotherapeutic drugs do seem to reflect a general moral stance—particularly concerning the values of strength and self-denial associated with the Protestant ethic. Consistent with such values is the finding that people are very unlikely to condone the use of a psychotherapeutic drug except in situations involving a real threat to important relationships or the ability to carry on important activities, such as work.

What is more remarkable is how consistent these beliefs and attitudes were among demographic subgroups of the population. Except for a tendency toward more liberal attitudes in the West and a greater likelihood for the least educated respondents to equate character weakness with the use of psychotherapeutic drugs, we found a striking similarity of attitudes among persons of disparate age, income, education, occupation, and sex. Clear-cut differences in attitude do exist between those who have used psychotherapeutic drugs and those who have not. Those who have used such drugs are more favorably disposed toward them on all the major issues we explored than are those who have never used such drugs. But even those who have used psychotherapeutic drugs appear to have considerable reservations regarding their use and do not appear to believe that drugs are an instant solution to all of life's difficulties and problems.

Although our findings suggest that people are more conservative in their approach to psychotherapeutic drugs than much of the current literature suggests, we want to stress the fact that no conclusions about the long-term implications of these findings can be reached. The relationship between attitudes toward drugs and use of drugs is complex. The decision to use or not use a psychotherapeutic drug is the result of a process involving many variables, including intensity of need and availability of alternative ways of resolving problems and relieving symptoms. Conversely, one's attitudes toward drugs are influenced by many personal experiences, including past use of drugs.

REFERENCES

1. Parry H, Balter M, Mellinger G, et al: National patterns of psychotherapeutic drug use. Arch Gen Psychiatry 28:769–783, 1973
2. Mellinger G, Balter M, Manheimer D, et al: An overview of psychotherapeutic drug use in the United States. Presented at the Epidemiology of Drug Abuse Conference, San Juan, Puerto Rico, Feb 12–14, 1973
3. Public information and attitude concerning tranquilizers, in Psychological Barometer Report. New York, Psychological Corporation, 1960, pp 1–9
4. Klerman G: A reaffirmation of the efficacy of psychoactive drugs: a response to Turner. Journal of Drug Issues 1:312–319, 1971
5. Festinger L: Conflict, Decision, and Dissonance. Stanford, Calif, Stanford University Press, 1967

The Road to Shangri-La Is Paved with Vitamins

BY REUBEN BITENSKY, PH.D.

A number of people have adopted a belief that vitamins can prevent disease and restore youth. The author examines the implications of this belief as it was uncovered in group therapy sessions. He discusses the liberalism and activism of these middle-aged group members in their younger years, the anti-establishment values of the vitamin cult, and the denial of aging by seeking eternal youth. The author concludes that their common belief in the powers of vitamins has not been beneficial to the growth and well-being of the group.

MUCH OF THE CONTROVERSY that has raged over the medical worth of vitamins has neglected to consider why a scientific issue should stir up such vehemence. In the heat of battle the contestants have not paused to ask why they are involved in the fray. The passions that have been aroused seem more typical of religious and political conflicts than of the investigations of medical science. Not since the controversy over the fluoridation of water, which has happily abated, has there been such polarization. In fact, "vitaminization" seems more apt to capture the minds and hearts of Americans than Vietnamization. Although I am not equipped to evaluate the therapeutic benefits of vitamins, nor do I wish to, it nevertheless seems to me that the whole subject could be approached more objectively if the psychological and ideological aspects of the vitamin crusade could be examined.

This was brought home to me when, in working with a

Dr. Bitensky is Associate Dean and Associate Professor, School of Social Work, Syracuse University, 926 South Crouse Ave., Syracuse, N.Y. 13210.

number of patients in group therapy sessions, I suddenly found the vitamin cult to be an intruder in our midst. The rapid conversion of the group to this cult first struck me as a benign, if somewhat ironic, eccentricity. It was ironic because all the members of the group were attributing to vitamins some magical potency to ward off disease while they were being beset by various ailments. Indeed, as the group members became freer to disclose their belief, they revealed their conviction that vitamins C and E would not only prevent disease but would restore youth. It seemed to me that in a sense such rallying under the banner of vitamins could be the cause célèbre of the older generation. If past generations could seek organ transplants from monkeys and if the young have their idiosyncracies, then why shouldn't today's older people see vitamins as the elixir of youth and the hope of the future?

However, I was soon to find out that treating the subject with tolerance and dispassion did not evoke a sympathetic chord. The group members interpreted my impartiality as a form of intellectual dilettantism. Moreover, they saw me as an agnostic who was undermining their faith in their tribal god. Thus, as time went on, I began to perceive that this was not merely a scientific dispute, but that it had distinct theological overtones. I began to be aware that a religion was at stake, with its high priests, its doctrines, and its rituals. To question the dogma was to contaminate the deep well of psychological gratification the cult offered its proselytes.

THE NATURE OF THE GROUP

To understand these psychological rewards, the nature of the group has to be considered. They were men and women of later middle age who, although they had achieved some successes in life, were frustrated in attaining the goals they had set for themselves in the sexual, social, and economic spheres, or in a combination of these. At the time they were still highly motivated for the future. What was common to them as a group was a high degree of emotional deprivation because of their failures and an intense investment in filling these lacunae. While these objectives seemed highly unrealistic given the passage of years, nevertheless they clung as a group to the illusion that in the near future—just around the corner—was the ideal love partner, the glittering pot of gold, or the stunning social coup. Unattainable as these goals were, it was maintaining the illusion that was paramount, and even the illusion was in danger of being dimmed by the approach of old age.

The character of this contradiction was brought home to the group members by their awareness that, while the attainment of their desires required ever greater expenditures of energy and will power, the onrush of time was depleting these precious resources. Psychologically, it became imperative to roll back or at least retard the aging process. For without their youth—or what was left of it—the ramparts of their dream worlds would be scaled by reality, and old age would have to be confronted. However, where there is a desire to be psychologically hoodwinked the answer is not long in coming. It was found in vitamins, particularly vitamin E. Here was the panacea for disease, the talisman against the aging process, and the elixir to rejuvenate body and soul.

Although various reasons have been given for the resurgence of the vitamin cult, these explanations tend to be universal in scope and there has been little exploration of why particular groups resort to this psychological pattern. Given the nature of the group I worked with, why did they gravitate to vitamin E? Why not deep-breathing exercises, faith healing, or the transmigration of souls? To understand why a particular group seeks a specific resolution for a problem one must understand not only the problem but also the nature of the group. In this respect, awareness of the psychological needs of the group is a sine qua non; these needs have been identified and described in the psychological and sociological literature on the subject. What has received scant attention is the extent to which ideological imperatives and the value systems of the members of the group may influence the choice of a solution in attaining new psychological levels of adjustment.

This phenomenon was highly visible in the group that I worked with as therapist. All the members of the group were of a progressive inclination and in their youth had ascribed to liberal activism. However, the debilitating effects of the passing years were making it more and more difficult—physically and psychologically—to practice activism. It was becoming less and less inviting to attend meetings, participate in committees, and enter into the political fray. At the same time they were loath to give up their image of themselves as crusaders for progress, for this would lower their own self-esteem as well as imperil the adulation of children, relatives, and friends.

THE VITAMIN CULT AND THE ESTABLISHMENT

Vitamins offered a way out of this cul-de-sac. Adherence to the vitamin cult was a means of preserving their image of themselves as anti-establishment, particularly in regard to the medical sector of the establishment. Had not Linus Pauling postulated that vitamin C was being attacked as a cure for colds because the pharmaceutical companies had a vested interest in spurious cold remedies? Was not vitamin E being downgraded by the medical profession because of its investment in the perpetuation of disease? This charge against the medical establishment in the United States was given all the more credence because of the crisis in the delivery of health services and the resistance of the AMA to liberal solutions. Thus the vitamin evangelists could point to the medical profession's reservations about vitamins as one more example in a long history of opposition to progress in medical service for the populace. (It may be noted, however, that they seemingly took no cognizance of the fact that, with the growing popularity of vitamins, the same pharmaceutical companies were earning substantial profits from the boom in vitamins.)

In another respect the vitamin cult represented an at-

tack upon the establishment through its link-up with the organic food zealots. This occurred because the therapeutic rationale for adding vitamins to the diet arose from the plausible charge that the food industry was processing the vitamins out of many foods. Therefore, the only effective method of getting sufficient vitamins was by the use of organic foods. The resulting alliance between the vitamin and organic food devotees (often they were the same people) brought the vitamin cult into confrontation not only with the medical empire but also with the food industry. Thus a Goliath had been created that would be a worthy adversary of any liberal David.

In such a conflict the image of the political crusader could be maintained and even strengthened with substantial rewards for one's self-concept. But it was crucial to this accomplishment that it involved only a minimal expenditure of energy. By ingesting vitamins one could fight the establishment with the kind of activism that required no more effort than swallowing. Moreover, the greater the dosage, the greater the witness to fervent liberalism and anti-establishment sentiments. The liberals in the group had discovered a holy rite comparable to the sacrament of the Eucharist. Through the substitution of vitamins they had created a political communion through which the dilemma of being a liberal activist without being active was resolved.

However, there was another way in which the vitamin cult answered the psychological needs of the group and this too arose from the anxieties, insecurities, and fears brought on by old age. As the years went by and as illness and thoughts of death loomed larger, the liberal ideology offered less and less consolation to the members of the group. Because of their beliefs it was difficult for them to seek the religious comfort of facing death in the promise of immortality. During their earlier years these liberals were either agnostics or atheists. This presented no problems during their youth and early middle age since illness and death were merely theoretical concepts and not concrete realities that required some psychological readjustment. But to resort to religious belief in later years would be a desertion of the liberal credo and a shattering of the crusading image that was at the core of their personalities. In this crisis it was once again the vitamin cult that unified the seemingly irreconcilable opposites of liberalism and religious orthodoxy.

The problem the group faced was that of staving off death without resorting to religious solutions. Since life in the hereafter could only be assured theologically, a dogma was necessary to provide immortality here on earth. Once again the vitamin cult came to the rescue by promising eternal youth, or at least postponement of the aging process. But why are vitamins more acceptable than other avenues to immortality? Here it becomes evident that the scientific emphasis inherent in the vitamin approach makes it compatible with the agnostic or atheistic value system of the group members. At the same time it also overcame the dilemma inherent in agnosticism and atheism, since it provided a rationale for dealing with death through the so-called youth-preserving properties of vitamins.

Here it is clear that the group members had to choose between two alternatives: they could retain their agnostic and/or atheistic beliefs or they could abandon their beliefs under the subterfuge that they were accepting a more scientific orientation in the vitamin cult. It is sufficient for our purposes to note that maintaining their agnosticism would have meant facing the limitations of old age and adapting to the realities of a new phase in their lives. On the other hand, the vitamin cult could preserve the illusion of youth and enable them to avoid—at least for some time—the necessity of regarding themselves as elderly. Interestingly enough, if character building is to be regarded as the outcome of confronting and dealing with the realities of living, it would have been adhering to their old beliefs rather than seeking the will-o'-the-wisp of eternal youth and the intimations of immortality promised by vitamins that would have contributed to their continued growth as individuals.

THE EFFECT ON THE GROUP

Given this new adjustment, how durable was it? Will this new homeostatic balance promote the cohesion of the group and will it foster the stability of the individual members? Already some stresses and strains are beginning to appear that augur ill for the psychological well-being of the group. There are signs that they are perplexed and uncomfortable with their status as a select group (one that has the quality of eccentricity rather than elitism) that is different from the remainder of society. It is a situation that conflicts with their cherished image of themselves as liberals since, although liberalism implies an advanced role in society, it is an integrated, not a deviant, position.

This insecurity in the group was mirrored in their doubts about the values of their colleagues. While each subscribed to the vitamin cult, they inwardly mistrusted their peers for adopting this stance and criticized them for abandoning the traditional tenets of liberalism. Differences between members of the group were thus exacerbated and they found it increasingly difficult to tolerate each other's company even though they held a common dogma. Only in dialogues about the curative powers of vitamins were they in harmony. However, when faced with the skepticism of friends and acquaintances outside the group, they tended to unite in categorizing the doubting Thomases as irredeemable, unenlightened pagans.

But why is the new psychological adjustment so tenuous? The ability to deal maturely with old age arises out of accepting its inevitability in order to philosophically and morally transcend its limitations. To live by the denial of old age, buoyed by fantasies of great expectations in the future, means to fail to live today. By giving up their value system and failing to face life's limitations the group first of all relinquished their tested liberal values and assumed the mantle of knowledge in an area in which they possessed no more expertise than the man in the street. They gave up being themselves and

took on roles that were unbelievable to their friends. Far from being secure, they became threatened and defensive. Their behavior was guarded, with an increasing lack of variety, nuance, and spontaneity in their thoughts and actions. Previously, when the group sessions first began, their interaction demonstrated their interest in art, politics, and ideas. Now there was a perseverative discussion of their ailments, of vitamins, and of organic foods. Their intellectual horizons extended only far enough to include ecology as a topic of conversation since this was related to the future of organic farming.

In retrospect it is evident that, if the group had refrained from attributing magical therapeutic properties to vitamins and had accepted the inevitability of old age, they could have retained their self-respect and the esteem of their peers. They denied reality as fraught with antithesis and suffering. They chose instead the easy way—the dream of Shangri-La—and, in the frenetic pursuit of their youth, they are in danger of losing what remains of their old age.

Physicians and the New Sexual Freedom

BY IRADJ SIASSI, M.D., AND MIVART THOMAS, M.D.

Articles in the popular press and books by mental health practitioners have raised the question of whether psychiatrists should have sexual relations with their patients. The authors compare the relationship between a physician and a patient with that between a parent and a child and conclude that sexual involvement with a patient impairs the empathy and objectivity that are necessary for therapeutic effect.

THE RISING TIDE of new sexual freedom that has been spreading through American society was bound to reach and challenge the hallowed relationship between physician and patient sooner or later. Typical of this trend was the lead article in a well-known women's magazine "Should You Sleep with Your Therapist? The Raging Controversy in American Psychiatry" (1).

Popular magazine articles, with their bent for sensationalism, can be ignored without much ceremony. The idea, however, seems to go beyond sensational journalism. For example, Dr. Martin Shepard, a psychiatrist with respectable credentials, raises a similar question in an entire book devoted to the subject (2).

Open and honest discussion about all aspects of human sexuality is one of the remarkable achievements of our generation. Another is the acceptance of sexual practices that vary from long-held conventional norms. A nonjudgmental attitude on the part of the physician toward the sexual practices of his patients has become one of the moral dicta of medical education. It was inevitable that the taboo against sexual relations between physician and patient should be challenged, questioned, or at the very least subjected to examination.

In most societies the physician-patient relationship has many of the qualities of the relationship between parent and child, e.g., maximum social intimacy coupled with maximum sexual distance. The fact that the physician is governed by the same sexual taboos that prevail between parent and child makes it possible for him to exercise prerogatives that would be inconceivable in a different situation. Such public trust is absolutely essential for the physician to be allowed to carry out his work; it has therefore been jealously guarded and enforced by both the public and the medical profession.

Just as it is the parent's responsibility not to exploit the dependent and helpless child, so too is it the physician's responsibility in a physician-patient relationship to avoid sexual indiscretion. The fact that the patient is willing, or may even be the aggressive initiator, is no more valid a justification than the claim of parents who engage in incest that the child was willing or was the initiator. For these reasons the medical profession's disciplinary committees have traditionally been very strict in interpreting the medical code of ethics in sexual matters. Retribution against the transgressors has tended to be swift, severe, and uncompromising; it frequently includes the loss of the guilty physician's license to practice. This unequivocal reaction clearly emphasizes the attitude that any sexual relationship between a physician and his patient will be considered an act of exploitation on the part of the physician; the burden of proving otherwise is always on the physician.

The authors are with the Institute of Mental Health Sciences, Rutgers Medical School, University Heights, Piscataway, N.J. 08854, where Dr. Siassi is Director of Adult Services and Associate Professor of Psychiatry and Dr. Thomas is Assistant Professor of Psychiatry.

The taboo against sexual relations between a physician and his patient is based more on pragmatic than on moral grounds. The medical model presumes a high degree of objectivity in the diagnosis, treatment, and prevention of illness. Moreover, the physician's task of helping the patient achieve health and well-being is facilitated by the establishment of rapport, i.e., a harmonious, nonthreatening relationship in which the physician is both an empathic participant and a dispassionate observer. It is the recognition that emotional involvement impairs the physician's judgment that prompts him to avoid treating the people in his life with whom he has strong emotional ties (his immediate family, for example). Any sexual involvement with the patient would also greatly impair a professional relationship that requires empathy and objectivity.

Even the most fervent advocates of total sexual freedom recognize the difficulties of a sexual relationship between nonequals. In the physician-patient relationship, the patient is often helpless and always dependent; a sexual liaison in such a situation has all the earmarks of exploitation. However, the authority and the prerogatives bestowed by society on the physician are in part predicated on the implicit trust that the physician will not engage in exploitation. Both the physician and society depend strongly on such trust—the physician in order to function effectively and society in order to rest easy about having invested so much power in one of its members.

This mutual interdependence makes the physician's position both delicate and precarious. This is all the more true in a democratic society where power is viewed with suspicion and distrust. The physician actually functions, as it were, in a fishbowl; it is only the public's belief in his trustworthiness and integrity that allows him the degree of freedom from the controls that a democratic society always puts on people in positions of power.

Whether or not some physicians betray this trust and engage their patients sexually should not affect the issue. Physicians are human and prone to human error. What is at issue is the shortsighted and destructive efforts of some physicians and nonphysicians to justify this error and even to seek some saving grace by ascribing "therapeutic benefits" to these relationships.

The consensus among students of society from Durkheim to Parsons is that society brings punitive sanctions against those who threaten its social cohesion. As long as the nuclear family continues to be the basic unit of society, taboos against incest will remain strong. It is equally probable that, as long as the physician-patient relationship exists, taboos against sexual liaisons between physician and patient will continue. To equate a sexual relationship between a physician and his patient with the other aspects of sexual freedom betrays ignorance of the basic tenets of society. The only comparable case is incest.

Hippocrates' admonitions of 2,000 years ago still hold. It is no wonder that the neophyte physician even now is called upon to take the oath: "Every house I shall enter for the sake of my patient's well-being, refraining from every intentional harm and all seduction, especially from love relationships with women or with men, be they free or bonded."

REFERENCES

1. Weber M: Should you sleep with your therapist? the raging controversy in American psychiatry. Vogue, Jan 1972, pp 78–79
2. Shepard M: The Love Treatment. New York, PH Wyden, 1971

Making Abortion Consultation Therapeutic

BY CORNELIA MORRISON FRIEDMAN, M.D.

The author presents an approach to psychiatric consultation before abortion that attempts to determine the extent of the woman's ambivalence about the abortion by clarifying any unconscious motivations or conflicts. Other goals are an evaluation of the woman's capacity to cope and an assessment of the quality of life that would be available to the infant.

THE PSYCHIATRIC COMMUNITY has for the most part responded favorably to the Supreme Court decision removing first-trimester abortion from state jurisdiction. Psychiatric consultation before abortion will now be used at the surgeon's discretion and will probably be limited to the severely ambivalent woman, the young teenager, and the emotionally vulnerable woman with previous psychiatric problems. This paper presents a systematic approach to such a consultation and is designed to promote its therapeutic value.

Dr. Friedman is Clinical Instructor in Psychiatry at Harvard Medical School. Address reprint requests to 25 Chestnut Hill Rd., Chestnut Hill, Mass. 02167.

Psychiatrists have long felt that the abortion decision belongs to the woman (1–5). The previous requirement of a psychiatric diagnosis to justify abortion placed the psychiatrist in an uncomfortable position. Studies have shown that the traditional grounds for therapeutic abortion, such as schizophrenia (6), postpartum psychosis (7), and suicidal ideation (8), are not valid since women with these conditions show no demonstrably greater difficulty coping with unwanted pregnancy than do other women. Therefore, if one were a purist it would have been difficult to state that any mental condition really *required* abortion. On the other hand, fears that abortion in and of itself causes severe psychic sequelae have proved unfounded. Most women tolerate the stress of abortion as they do the other traumas of life—that is, with upset feelings but without emotional disability.

What I want to say is not new. Careful psychiatric consultation was mentioned frequently in Calderone's summary of the 1955 Planned Parenthood Federation Conference on Abortion (9). Rosen, in his book *Therapeutic Abortion*, published in 1954 and recently republished (10), described the complexities of some abortion consultations. As Calderone's book stated, "There are conflicting drives and it is so many units on one side that we cannot measure and so many units on the other side that again we are not able to measure; and that is seen in every aspect of this material" (9, p. 124).

My case material is drawn from several hundred abortion consultations. These were done in private practice; at the Harvard Community Health Plan, a prepaid health maintenance organization serving a heterogeneous working-class population; and at Boston Hospital for Women, where women of all racial backgrounds and of low socioeconomic status were seen. In addition, consultations at the Crittenton Home in Boston provided case material from patients who were approved for abortion but who decided instead to have their babies.

THE GOALS OF THE CONSULTATION

I will discuss the psychiatric interview as a potentially therapeutic experience for certain women. The interview focuses on: 1) the woman's ambivalence, 2) her capacity to cope, and 3) the quality of life available to the infant. The focus of my discussion is conflictual situations that have been uncovered in consultation for abortion; an assessment of the woman's ambivalence is easier after clarifying any unconscious conflicts that have resulted in exposure to pregnancy and conception. The emotional conflicts associated with unwanted pregnancy are diverse and complex, and experience with a wide range of women seeking abortion has revealed no single way to characterize them. Previous studies concentrating on a single dynamic or personality constellation have perhaps been limited by a too homogeneous patient population.

The major goal of the psychiatric consultation is to determine the extent of the woman's ambivalence about the abortion. Is the woman convinced that she does not want to have this child? In weighing her ambivalence, it is important to clarify with the woman any unconscious motivation for the pregnancy. A decision to bear a child is based ideally on a woman's mature longing for the child, her capacity for motherly giving, and adequate reality supports. Discussion of unconscious motivations gives the woman a clearer perspective of her inner and outer reality. She is then more free to make her decision on the basis of her mature feelings and her realities.

A secondary goal is the evaluation of the woman's capacity to cope with the pregnancy or abortion. Ekblad (11), in his study of 479 women, found that the only patients with severe emotional sequelae to the abortion were ones who had considerable emotional difficulty earlier. He pointed out that the real irony of abortion laws lay in the fact that "the greater the psychiatric indications for legal abortion are, the greater will be the risk of unfavorable psychic sequelae after the operation." Ekblad found undesirable sequelae in 11 percent of the 479 women and Sim (7) in four percent of 213 women. Expressing concern about these women, Sim stated, "The only proper role for the psychiatrist, should abortion become legal, would be to help decide who should *not* be aborted."

Women who are vulnerable are not difficult to detect for they usually have a psychiatric history and their management is not easy. Either continuing the pregnancy or having an abortion would be stressful. In the past psychiatrists have tended to assume that a continued pregnancy is less difficult than an abortion. However, we must learn more about this vulnerable group before conclusions can be drawn. (I anticipate more careful studies of women with maladaptive responses to abortion now that researchers are no longer occupied with proving that most women respond adaptively.) In the last analysis, it may not be the extent of psychopathology that causes difficulty for a woman but rather her inability to choose the abortion without marked ambivalence.

Another goal of the interview is the estimation of the quality of life available to the infant if he is born. Forssman and Thuwe (12) have demonstrated the increased difficulties for illegitimate and unwanted children. Raven (13) and others have pointed to the high incidence of unwantedness among battered infants and babies who died of crib death.

During the consultation I make two basic assumptions: 1) that a biologically mature woman will naturally seek sexual gratification and 2) that contraceptive information and devices are sufficiently available that the average woman can prevent pregnancy. Genuine contraceptive failure is occasionally encountered—for example, pregnancy with an intrauterine device in place. However, in my experience, the far greater number of unwanted pregnancies result from irregular use of contraceptives. For example, one hears fairly often of pregnancy occurring while a woman is switching from the pill to another form of contraception. Upon inquiry, one usually learns that the couple used no contraception at all during the interim.

So I ask: Why is this woman pregnant? I organize the search for the answer to this question around the

woman's relationship with her sexual partner. The resulting focus is helpful, since a person's capacity to form a stable, intimate relationship is the culmination of complex ego functions. The use of this focus tends to group individuals who are similar in their stability, capacity for feeling, sexual adjustment, resolution of dependence-independence conflicts, and tolerance for narcissistic frustrations. However, as with any system of psychiatric categorization, its very conception immediately provokes thoughts of exception.

UNWANTED PREGNANCY IN A STABLE MARRIAGE

A married woman seeking an abortion who has a viable, satisfying relationship with her husband may be struggling with the following conflicts:

1. Ambivalence about taking a more active, independent stance in life. Such a woman is often middle-aged, with higher education and some ambitions for herself. She is an organized individual, with a family of the size she planned. Her children are in school and are investing more of their energies outside the home. The woman may have made some efforts to seek employment or further education and felt vaguely anxious. Uncharacteristic laxness or memory lapse regarding contraception has resulted in pregnancy. The pregnancy protects her from her unconsciously feared independence but is consciously rejected because her family is complete. This woman is often surprised and irritated with herself.

2. Ambivalence about giving up the nurturant intimacy with an infant. This young woman's "last" child is a toddler, but she has special feelings about "having a baby in the house." She is well adjusted, but close scrutiny reveals her deeper investment in the current infant of the family than in the more mature members of the household, including her husband.

3. Fear of aging or loss of femininity by ending the childbearing period. I recall a woman of mature years whose family was complete. Through uncharacteristic laxness with contraception, she had become pregnant in the premenopausal period. This was her 11th pregnancy; she had eight children. She loved children and said that if she were only younger, she would like to have this child and even more. Although it was not true in this case, a woman with a premenopausal pregnancy will often have been uncertain about her femininity earlier in her life. There may have been conscious fears of childlessness or some realistic threat to childbearing. She may desire to carry this pregnancy to term but be embarrassed about what her older children or friends will think of her middle-aged motherhood.

4. Religious conflicts. These are seen in women who no longer practice their faith but remain tied to it by guilt. This was clearly the dynamic in a former Roman Catholic who was married outside the church and who, in a panic, sought consultation for an abortion. She used contraceptives regularly but had forgotten to take her pill while she was visiting her parents for the weekend. Her guilt and fear of punishment were evident in her panic.

5. Ambivalent competitive or grandiose fantasies about family size—e.g., a woman who has unwittingly channeled much ambitious striving into reproduction. She has tended to deny the considerable responsibility of each additional child. However, as time goes on, the rigors of motherhood may provide too little satisfaction and her denial may break suddenly after another pregnancy begins.

In most of these situations the woman is partially or completely aware of her emotional conflict. Often the pregnancy forces introspection and gradual awareness. In these cases the psychiatric consultation clarifies the woman's awareness and gives her an ally in mobilizing her strengths to resolve the ambivalence or conflict. Clearly, the husband's feelings about the pregnancy are an important consideration. Occasionally a husband will want another baby as proof of his continuing virility when a wife would prefer abortion. In my experience husbands or lovers attend abortion consultations only infrequently—about five percent of the time. The man's feelings are always discussed in these consultations. One may hope that now that the goal of the interview is no longer obtaining consent via establishing a psychopathological diagnosis, men will more frequently request and be requested to take part.

UNWANTED PREGNANCY IN TROUBLED MARRIAGES

Unwanted pregnancies occurring in married women with troubled relationships with their husbands tend to be associated with the following situations:

1. Intense conflict about divorce that the woman seeks to settle by impulsive action rather than anxiety-laden confrontation. I have seen several cases in which the unwanted pregnancy occurred just as the woman's desire for separation was crystallizing.

2. Stressful unwanted pregnancy in an improving marriage involving a markedly masochistic woman. One woman became pregnant after she had stopped taking the pill and was waiting for an appointment for a new contraceptive. This woman had three children, born during a previous long, unhappy marriage. She had been remarried for a year and was able to return to college since her children were old enough for school. Her adjustment to her second marriage was initially difficult, and she raged at her new husband for not solving all her problems. However, he took it calmly and eventually she stopped storming and had her first prolonged period of stability in ten years. She was furious at the untimely pregnancy, which threatened her new-found enjoyment in living.

3. Expression of anger at the husband for his absence, heavy drinking, or other behavior that is seen as his lack of caring. While this anger may have some realistic basis, it is often related to some expectations in the woman for parental care. Under this category I would include the women recently described by Biele (14) as having "depressive practices." Biele described a personality constellation including vindictiveness, manipulativeness, and anxiety. When the woman's covert maneuvers to control

fail, she resorts to exposure to pregnancy as an expression of her anger and anxiety.

In the above situations the psychiatrist must evaluate both the stability of the woman and the state of the marriage, and consider referral for individual or couple therapy. There is a tendency for women in this group to have more psychopathology—i.e., graver conflicts about passivity, greater dependence, deeper sadomasochistic tendencies, and deeper pregenital longings. Often referral for marital counseling or psychotherapy is indicated but seems pointless because the woman resists treatment. A clear statement about the problem may nevertheless be heard by the woman and stored for future reflection.

ILLEGITIMATE PREGNANCY FEATURING A RELATIONSHIP WITH THE MAN

Illegitimate pregnancies occur in women who have full relationships with the father of the baby and women who have no relationship at all. When a real relationship exists many of the previously mentioned issues will be seen. In addition, the psychiatrist may see:

1. Markedly dependent or sadomasochistic relationships, in which the woman deliberately conceives to force a marriage. If the man refuses, the woman often is left with little desire for the child. Evaluation of the woman's attitude toward abortion is crucial. She is struggling with rage at the man for abandoning her. If she views abortion as a murderous act, she may see it masochistically; that is, she will hurt herself to show the man how bad he is. Once the abortion is performed, her guilt about her rage and the death of the fetus, as well as her inevitable frustration about the relationship, can cause a severe state of turmoil. Detection and discussion of this motivation before any decision may reduce subsequent guilt and turmoil.

2. Angry rebellion in a teenager who wishes to marry a boy forbidden by her parents. The girl has assumed that her parents will consent to her marriage when they are confronted with a pregnancy. Often she does not want an abortion, seeks it only after coercion by her parents, and refuses it when given the option. Such a girl's rebellion against her parents prevents her accepting the abortion; she chooses instead the physical rebuke of a growing abdomen. These cases can be incredibly complex. Careful questioning about the parents' disciplinary methods usually reveals wide swings between permissiveness and harsh, rigid control. A referral to a maternity home with an active social work staff sometimes achieves good results. The emotional pressures of the pregnancy force recalcitrant families to reconsider their embittered positions.

3. The appearance of a series of real relationships with men, resulting in a series of pregnancies and abortions. Often the men are of different racial or ethnic backgrounds. These girls have severe hysterical character problems, with strong depressive elements. They are searching for something from their fathers in these relationships; that something is partly sexual but more largely something involving closeness and nurture. The pregnancy is desired, so contraception is faulty; the pregnancy is forbidden because of its oedipal association, and abortion follows. This is a complex pattern, and it requires insight-oriented psychotherapy in order to effect any change.

ILLEGITIMATE PREGNANCY WITH NO RELATIONSHIP WITH THE MAN

Finally, psychiatrists see women who have no lasting relationship with the father of the baby. This group tends to be the youngest and most disturbed of the groups discussed and includes the following:

1. Women with physical defects (usually congenital), abdominal operations, or recent miscarriages who are concerned about their ability to be normal. These women equate normalcy with reproducing. A recently married woman illustrates this dynamic nicely but defies my system of classification because she maintained a fairly good relationship with her husband. She had had a severe episode of gonococcal endometritis and was told that she had been treated just in time to save her fertility. Vague concerns about this at the time turned after her marriage into a persistent fear that she might be unable to conceive. Her birth control method had for several years been a risky combination of rhythm and condoms. It is interesting to note in passing that her method failed her only in this emotional setting.

2. Women whose sense of themselves is failing. Heroin addicts or borderline psychotics may become pregnant in a desperate attempt for integration. Obviously, to approve an abortion for such a woman without providing good psychiatric care is to miss the point; this group is highly vulnerable.

3. Young, deprived, and delinquent teenagers who actively seek pregnancy to have something to love. I am referring to girls like Gedo's (15) patient, who revealed in analysis that her illegitimate pregnancy was in part "an attempt to fill a sense of inner emptiness and depression." Gedo noted that his patient insisted on incorporation of an object or nothing at all. Often such a girl does not desire an abortion, but accepts it on the advice of a therapist who starts to give her the affection she so craves.

4. The highly narcissistic, rather grandiose young woman who decides to have a baby just because she wants one and is not in the least embarrassed to describe her motivation in this way. This group is small in number; the woman usually does not follow through with the abortion even if it is approved. She likes the father of the baby well enough, but cares little whether he stays with her because her primary investment is in herself. She has fantasies about the gratifications of the mother-child relationship and sees no point in postponing them.

CONCLUSIONS

I have presented an approach to psychiatric consultation before abortion to maximize the therapeutic poten-

tial of the experience. The primary goal of this consultation is to determine the extent of the woman's ambivalence about the abortion. In order to do this, the consultant uncovers and clarifies any unconscious motivation or conflict, helping the woman to obtain a truer perspective of her inner and outer reality. A second goal is the evaluation of the woman's coping capacity; there is evidence that the small number of women with marked post-abortion emotional sequelae have been unstable previously. Such women clearly need good supportive follow-up if abortion is chosen. A third goal of the consultation is the assessment of the quality of life that would be available to the infant.

I have described a number of conflictual situations associated with unwanted pregnancy. In these situations, the conflicts are diverse and the woman's feelings and relationships are complex. It will require an experienced, skilled, and insightful evaluator to sort through some of these situations. In clinical situations where there is no routine psychiatric screening, it is important for personnel to learn through experience which women require psychiatric consultation or aftercare. In addition, recommendations for further therapy must be tailored to the individual.

Foremost in the interview is the discussion with the woman of the unconscious and conscious determinants of her pregnancy. She needs to know whether the pregnancy is a genuine accident or the expression of some hidden wish or fear. Knowing this, she can more realistically appraise her life situation and her capacity to care for an infant. The tragedy of past abortion laws was that they provoked women to struggle with false issues. Feeling that abortion might be denied, the woman panicked and concentrated on obtaining the abortion. The real human issues for a woman with an unplanned pregnancy are her mature longing for a child, her present capacity to love and give, her present reality, and a weighing of her morality.

REFERENCES

1. Sloane RB (ed): Abortion: Changing Views and Practices. New York, Grune & Stratton, 1971
2. Aarons ZA: Therapeutic abortion and the psychiatrist. Am J Psychiatry 124:745–754, 1967
3. Group for the Advancement of Psychiatry, Committee on Psychiatry and Law: The Right to Abortion: A Psychiatric View. Report 75. New York, GAP, 1969
4. Lebensohn ZM: Abortion, psychiatry, and the quality of life. Am J Psychiatry 128:946–951, 1972
5. Crowley R, Laidlaw R: Psychiatric opinion regarding abortion: preliminary report of a survey. Am J Psychiatry 124:559–562, 1967
6. Simon A: Psychiatric indications for therapeutic abortion and sterilization. Clin Obstet Gynecol 7:67–81, 1964
7. Sim M: Abortion and the psychiatrist. Br Med J 2:145–148, 1963
8. Anderson EW: Psychiatric indications for termination of pregnancy. J Psychosom Res 10:127–134, 1966
9. Calderone MS (ed): Abortion in the United States. New York, Hoeber-Harper, 1958
10. Rosen H (ed): Abortion in America. Boston, Beacon Press, 1967
11. Ekblad M: Induced abortion on psychiatric grounds. Acta Psychiatr Neurol Scand (Suppl) 99:1–238, 1955
12. Forssman H, Thuwe I: One hundred and twenty children born after application for therapeutic abortion refused. Acta Psychiatr Scand 42:71–78, 1966
13. Raven C: Testimony in favor of abortion reform, hearings before the Michigan State House Committee on Social Services. The Woman Physician 26:584–586, 1971
14. Biele A: Unwanted pregnancy: symptom of depressive practice. Am J Psychiatry 128:748–754, 1971
15. Gedo J: Unmarried motherhood: a paradigmatic single case. Int J Psychoanal 46:352–357, 1965

Marriage, Family, and Parenthood

BY HENRY GREENBAUM, M.D.

The author discusses the recent attacks against marriage, family, and parenthood by some of the leaders of the Women's Liberation Movement. He points out that the difficulties that cause human suffering in these institutions are not intrinsic to them but are determined by the quality of the people involved in them. He believes there is a deep human need for marriage, family, and parenthood, which has its roots in the prolonged biological and psychological dependency of the human child. The conditions of personality development necessary for successful functioning in marriage, family, and parenthood are analyzed.

MARRIAGE, family, and parenthood have recently come under attack by some extremist leaders and writers of the Women's Liberation Movement. The alternatives they propose are fuzzy and bear the earmarks of instant solutions to complex biological, psychological, and social problems. No doubt the social institutions of marriage, family, and parenthood have frequently been the cause of much human abuse and suffering, but the remedies offered amount to throwing out the baby with the bath water.

I believe the women's drive for equal rights is morally, politically, and historically justified and constitutes a progressive force in society. Nevertheless, some aspects of it do elicit criticism. Some feminists appear to believe that there are magical effects in destroying institutions that have developed by trial and error over thousands of years of social evolution. Barbara Balogun (1) said about marriage:

> I feel that the personal relationships of marriage must undergo a revolution ... the roles of male and female must be completely redefined—*no, eliminated.* I do not see this as possible in the present relationships of marriage.... The only alternative, as I see it, is communal living.... I also recognize that, conditions being what they are at the present time, most men feel so secure in their oppressive role that they will not give up their power willingly. Therefore, male-female communes will be impossible to establish. *It may be that our only solution will be the dissolution of marriage, with the foundation of all-female communes to eliminate the burdens placed on women* (pp. 293–295; italics mine).

Linda Gordon (2) has also written against the family: "Families perpetuate themselves and their bad values by educating children to see them as the only model for adult life.... *The nuclear family must be destroyed, and people must find better ways of living together*" (p. 187; italics mine). Simone de Beauvoir (3) saw no satisfaction in marriage and motherhood:

> The tragedy of marriage is not that it fails to assure woman the promised happiness ... but that it mutilates her; it dooms her to repetition and routine.... At twenty or thereabouts mistress of a home, bound permanently to a man, a child in her arms, she stands with her life virtually finished forever. Real activities, real work, are the prerogative of her man: she has mere things to occupy her which are sometimes tiring but never fully satisfying (p. 478).

These are but a few examples of feminist attitudes toward marriage, family, and motherhood. Until now man, overtly or covertly, has downgraded these institutions. Until now male-shaped society downgraded women who were not married or did not have a family. Now, if the feminists have their way, women who marry and have children will be downgraded and condemned as inferior beings.

William V. Shannon (4) described succinctly the attitude of many feminists:

> It is the function of advanced groups like the professional feminists to articulate what is only implicit in the behavior of a much larger group. That is the inner logic of their downgrading of woman's biological role, their angry depreciation of motherhood, their insistence on every mother's right to park her baby in a daycare center and hurry off to work even when financial circumstances do not require her to do so.

So we see it has happened again; history is repeating itself. An oppressed social group is raising its voice in protest against the oppressor and in the process it is identifying with the values and methods of the oppressor. This was the case with the French Revolution, which overthrew the despotism of absolute monarchy in 1789 only to replace it with the despotism of terror. It was also the case with the Russian Bolsheviks, whose tyranny equaled the tyranny of the czar they overthrew in 1917. In recent years in America some black leaders have adopted separatism as an instrument for liberating their people. And now the Women's Lib Movement seems to be following suit. I think some feminist attitudes reflect a harshness, intolerance, and self-righteousness that antagonize even their friends.

The Redstockings Manifesto (July 7, 1969) provides an example of this (5): "Women's submission is not the result of brainwashing, stupidity or mental illness but of

Dr. Greenbaum is Associate Clinical Professor of Psychiatry, New York University School of Medicine, New York, N.Y. His address is 65 Tennis Place, Forest Hills, N.Y. 11375.

continual daily pressure from men. *We do not need to change ourselves*, but to change men" (p. 110; italics mine).

It seems logical that, to improve the quality of life and to create equality and harmony between men and women, both have to change radically. Before we destroy existing institutions, we ought to remember that, just as men and women abuse and exploit each other in marriage, they may do the same thing in a commune. And if certain men and women as parents are unkind and cruel to their own children, what assurance is there that workers in daycare centers will not be even more cruel to the children in these centers?

THE QUALITY OF INSTITUTIONS

Of course no social institution should be held sacred. Social institutions have a raison d'être only if they serve men, women, and children by enhancing their security and their happiness through self-realization. For example, the institutions of slavery, feudalism, prostitution, war, and the like are based on exploitation and oppression of man by man; although they have been the products of historical necessity, they no longer serve modern man and are therefore obsolete. Even the institutions of capitalism and communism are questionable as far as man's long-range needs and the survival of civilization are concerned. Too many elements that can oppress the individual are built into these systems.

The institutions of marriage, family, and parenthood on the other hand are a different story. Inequality of spouses, exploitation of one another, and the mistreatment of children are possible in these institutions but are not intrinsic to them. The quality of these institutions is determined by the quality of husbands and wives, of mothers and fathers, as people. Mature people are able to make of these institutions a source of strength and satisfaction for both the individual and society. No wonder Lidz (6) wrote:

> A larger proportion of the population is married than ever before. It appears as if people living in an insecure world in which values and purposes are obscure have intuitively realized that meaningful values can be found in the relationships between spouses and between parents and children.... Despite the inevitable frustrations and even despite tangible failures, the vast majority of persons seek a more enduring happiness in firm family relationships.

When Linda Gordon (2) wrote that "the break-up of the families *now* is an objectively revolutionary process" and "the women's liberation movement should support and encourage women and young people who are leaving parents, leaving husbands, trying to avoid marriage and/or pregnancy," she demonstrated a lack of understanding of a deep human need for marriage, family, and parenthood. This need has its roots in the prolonged biological and psychological dependency of the human child. The dependency, which lasts about 18 years, brings the growing child into intimate relationship with his parents, and this has a humanizing, civilizing, and socializing effect upon the child. It imprints on him psychic qualities that no other species has developed—namely, a need for enduring love (both to love and to be loved); intimacy; interdependence; loyalty and devotion; commitment and responsibility; security against loneliness in time of illness, old age, or other existential crises; and stability.

Sex is not one of the basic reasons for marriage, because sexual satisfaction can be obtained outside of marriage. However, sexual love is an important vehicle for the fulfillment of the above-mentioned needs for marriage and marriage in its turn becomes an effective vehicle for sexual expression.

There is a widespread misconception that romantic love cannot endure in a long-lasting marriage. It is true that men and women can be biologically attracted to people other than their spouses and that this can be a disrupting factor in marriage. However, psychosexual maturity enables both men and women to integrate extramarital sexual stimuli and redirect them toward their spouses, in the same way that hostile stimuli can be redirected from one person to another. It therefore seems to me that mature spouses who are in love with each other and who have a desire to please each other can consummate their sexuality in a very satisfactory and mutually enriching way throughout an enduring marriage.

CAPACITY FOR INTIMACY

In order to function successfully in marriage, a person must have successfully gone through the different stages of personality development and reached the stage that Erikson calls intimacy. But it is only after the previous stages, described by Erikson as basic trust, autonomy, initiative, industry, and identity, have been successfully established that real intimacy is possible. "Intimacy," Erikson wrote (7), "is really the ability to fuse your identity with somebody else's without fear that you're going to lose something yourself. It is this *development of intimacy which makes marriage possible as a chosen bond. When this has not developed marriage is meaningless* (p. 48; italics mine).

Erikson differentiated between real intimacy, which is characterized by a genuine capacity for love, affection, friendship, and sexual tenderness, and the pseudo-intimacy of the earlier stages of adolescence. People with a sense of pseudo-intimacy fail in marriage and shy away from parenthood because they have not reached in personality development the stage of generativity, which enables an individual to "care for" somebody or something and to "take care of" that which needs protection and attention:

> The principal thing is to realize that this [generativity] is a stage of the growth of the healthy personality and that where such enrichment fails altogether, regression from *generativity* to an obsessive need for *pseudo-intimacy* takes place, often with a pervading sense of stagnation and interpersonal impoverishment (8, p. 97).

It is widely accepted that children need loving parents in a loving environment to develop a healthy personality. However, it is less widely recognized that adults, both men and women, have a need to rear children in order to enhance their own self-realization and to achieve fulfillment of some of their emotional, mental, and social aspirations. Therese Benedek (9) wrote: "The child represents not only the parent's self as a child but also, or more so, his hope and expectations of self-realization through the child. Parents and children strive toward this goal through the unconscious process of reciprocal introjections and identifications" (p. 400). In discussing the relationship between the adult child and the aged parent, Benedek (10) wrote:

> As once the parent was the need-fulfilling object of the child, now that "adult child" is the need-fulfilling object of the aged parent. . . . Originating in the instinct for survival in the offspring, parenthood establishes a sense of identity that integrates the biologic and social functions of the personality (p. 205).

Although there are those who, because of realistic or intrapsychic reasons, do not become parents, it is important to recognize that parenthood is a natural phase in the healthy adult (8–11). Anthony and Benedek (12) wrote: "Parenthood is a manifestation of 'natural man' and, as such, is governed by the laws of biologic processes that are universal."

THE FUNCTIONS OF PARENTHOOD

The complexities of parenthood are immense. Suffice it to say that it can be a source of great joy and happiness as well as of anguish and turmoil of a nature probably little known in other phases of life. It can mobilize feelings of altruism, devotion, and commitment and a sense of responsibility toward offspring that are only rarely observed in nonparenthood situations in people who have a special gift for dedication to high altruistic ideals or to artistic creativity.

Parenthood represents for many people a hedge against loneliness and the existential insecurity of old age and infirmity. It also fulfills to some degree the wish for immortality and it provides the individual with another chance to relive his own childhood and adolescence, with the opportunity to master some of his past traumatic experiences. For instance, one of my patients, who was taken to a concentration camp at the age of ten and survived without her parents, felt that the opportunity to care for her own daughter was of great help to her in overcoming the painful effects of the deprivation of mothering in her own childhood. Thus we can say that mothering promotes growth and has a humanizing effect on both mother and child.

As we see, parenthood is an important stage and child rearing is an important function in the life of the adult. To downgrade them is to ignore deep human psychological needs. Germaine Greer (13) presents a case in point. Lacking experience in matters of family and parenthood, she has stated authoritatively: "Those families in which the parents replace themselves in two children are not the most desirable ones for children to grow up in" (p. 231). Psychoanalytic experience seems to contradict this view. Lidz (6), for example, wrote:

> The isolated nuclear family structure that has developed through industrialization and urbanization is better suited than the extended kinship family for training its offspring for the adaptability required in a rapidly changing world. . . . Its stability and capabilities depend primarily upon the personalities of the spouses who unite to form the family.

Germaine Greer (13) believes that a woman who has a child is not automatically committed to bringing it up and that a group of children can be more successfully reared by one or two hired women than by a "bored and imposed upon" mother. (The mother is ipso facto the villain—bored and imposed upon.) True to her beliefs, it is her plan, when she has a child, to have it brought up with other children by an Italian family living in a farmhouse, without letting the child know she is his "womb-mother," so that she can also have relationships with other children. This is absurd. Psychoanalysts who treat adopted children know how often they are tormented and disturbed by the question of why their biological mothers abandoned them.

After downgrading family and motherhood, the logical thing to do for certain feminists is to recommend institutional care of children. Hence the campaign for children's daycare centers. There is no doubt that mothers of small children who must or prefer to work should have access to the services of high-quality day centers. But I believe that the Women's Liberation Movement would make a greater contribution to society's well-being if it demanded that parents of small children receive sufficient welfare assistance to be able to rear them themselves if they so desire. And if both parents work, they should be entitled by law to paid part-time leaves of absence so that they may share in rearing their children.

Psychoanalytic experience shows that family care is preferable to institutional care. "To develop a child with a healthy personality," Erikson wrote (8, p. 98), "a parent must be a genuine person in a genuine milieu." I believe the family is the genuine milieu. It can be considered the cradle of mental health or mental illness and it is a social responsibility to preserve and upgrade the family. One could say that the quality of life and of our civilization depends on the quality of the family and the quality of parenthood.

It is noteworthy that 20,000 women responded to a questionnaire prepared by *McCall's* magazine (March 1971) on how women felt about issues raised by the Women's Liberation Movement. The majority (76 percent), regardless of age, felt that young children need a full-time mother.

I agree with Benjamin Spock's statement: "I myself would say it is much more creative to rear and shape the personality of a fine, live child than it is to work in an office or even to carve a statue." However, the modern woman is fortunate in that there is no need for her to

choose between the creativity of family life and the creativity of work. Both can be integrated in a system of values that become conflict-free guidelines for harmonious living. Madame Curie presents a good example of such integration. She was both a dedicated mother and a brilliant scientist.

CONCLUSIONS

As a psychoanalyst I am in deep sympathy with the Women's Liberation Movement. I believe that inequality between men and women prevents genuine love, friendship, and cooperation between them in marriage, family, and parenthood and thus frequently becomes a source of mental illness. Women have made great strides in their struggle for equality in the past half-century. Today, their emancipation is still far from complete and needs the wholehearted support of all men who aspire to a better quality of life. But I take exception to views on marriage, family, and parenthood that, if implemented, would lower the quality of life.

I do not claim to know which ultimate forms the relationship between men and women should take in order to assure a healthier humanity and a better quality of life. But whatever form our evolving institutions do take will depend to a great extent on our moral value systems and the quality of people.

REFERENCES

1. Balogun B: Marriage as an oppressive institution/collectives as solutions, in Voices from Women's Liberation. Edited by Tanner LB. New York, New American Library, 1971, pp 293–296
2. Gordon L: Functioning of the family. Ibid, pp 181–188
3. De Beauvoir S: The Second Sex. New York, Alfred A Knopf, 1971
4. Shannon WV: Flight from children. New York Times, July 15, 1971, Op Ed page
5. Redstockings manifesto, in Voices from Women's Liberation. Edited by Tanner LB. New York, New American Library, 1971, pp 109–111
6. Lidz T: The Family and Human Adaptation. New York, International Universities Press, 1963, pp 37–38
7. Evans RI: Dialogue with Erik Erikson. New York, Harper & Row, 1967
8. Erikson EH: Identity and the life cycle. Psychol Issue 1(1):50–100, 1959
9. Benedek T: Parenthood as a developmental phase. J Am Psychoanal Assoc 7:389–417, 1959
10. Benedek T: Parenthood during the life cycle, in Parenthood: Its Psychology and Psychopathology. Edited by Anthony EJ, Benedek T. Boston, Little, Brown and Co, 1970, pp 185–206
11. Lidz T: The Person: His Development Throughout the Life Cycle. New York, Basic Books, 1969, pp 440–455
12. Anthony EJ, Benedek T (eds): Introduction, in Parenthood: Its Psychology and Psychopathology. Boston, Little, Brown and Co, 1970, pp xvii–xxiv
13. Greer G: The Female Eunuch. New York, McGraw-Hill Book Co, 1971

Religious Delusions in Counter-Culture Patients

BY PERITZ LEVINSON, M.D.

Messianic delusions—until now rather rare and poorly understood—appear to be increasing in incidence and to be influenced by the values of the counter culture. The author identifies the principal clinical features of delusions: the belief in one's omnipotence and omniscience, the avoidance of affect-laden experiences and thoughts, the pursuit of asceticism, the experience of exalted mystical states, and the tendency to form symbiotic relationships that are devoid of meaningful emotional investment. The author discusses the treatment of this difficult problem and offers observations from his clinical experience.

RECENT TIMES have seen the rapid growth of counter cultures (1) among the youth of this country. The hippie movement gained many adherents; its recent dissolution has been followed by an array of subcultures such as religionists ("Jesus freaks"), naturalists ("environmental freaks"), occultists ("astrology freaks"), and others. The features that remain from the parent hippie culture are a rejection of the values of the establishment and a dedication to peace, purity, universal camaraderie, and the pursuit of pleasure. Drug use, long hair, and characteristic dress, music, and food have been widely adopted by people who are not in counter-culture groups.

Dr. Levinson is an Associate in Psychiatry at Mount Sinai School of Medicine, New York, N.Y. His address is 120 East 89th St., New York, N.Y. 10028.

The author would like to thank Lloyd H. Silverman, Ph.D., for his helpful comments during the preparation of this manuscript.

An abrupt increase in the incidence of religious delusions was noted among patients admitted to a general psychiatry service in a large city. In the cases that were selected for study, religious delusions were the central and dominant symptoms of the psychosis rather than inconsistent and minor features. Each of these patients was found to be strongly influenced by counter-culture factors. A review of the records from 1970 to 1972 yielded eight cases of persistent religious delusions, compared with only one case during the preceding two-year period and six cases out of 25,000 in the Michigan state hospital system in 1958 (2). The eight subjects, who were men between the ages of 18 and 26, were from 185 first admissions in this age and sex grouping. The delusions usually occurred as part of an acute schizophrenic process and involved the subject's identifying himself as Christ, believing he was on a messianic and prophetic mission, and believing he was able to communicate with beings of a higher order by means of hallucinations.

Each subject was found to clearly reflect counter-culture influences. Besides the outer trappings, this was manifested in the popularity of vegetarianism, Eastern religions, mysticism, meditation, and uncontrived approaches to relationships. Although other patients who were admitted during the two-year period reflected a variety of counter-culture influences, none exhibited clear-cut and persistent religious delusions. Instead, these patients presented more traditional symptoms, such as depression, confusion, and paranoid thinking. Our eight subjects were studied intensively for the psychodynamic determinants of the religious delusions, the influence of the counter culture, and the unique ways in which these patients coped with stress.

PRINCIPAL CLINICAL FEATURES

Each subject was admitted to the hospital with the grandiose religious delusion that he was "Jesus Christ," "the son of God," or "the Messiah." The patient's identification with Christ generally reflected an accepted religious belief, but there was some variation in this. For example, the delusion often included the conviction that he had the power to control people's minds, to read the minds of others, or to cure illness. This control of others would render them submissive followers; the patient often read into the casual glances of others unusual significance such as acquiescence, deep understanding, and silent adoration. In addition the patient believed he could put people "in touch with their feelings," make them able "to discover real truth," and "liberate" them. The messianic claim sometimes included the conviction of having achieved Nirvana and of being able to lead others to this prized state of exaltation. One patient had written a 1,700-page volume of "truths," which he regarded as a new Bible.

Along with these narcissistic elements, these patients were generally withdrawn, intellectualizing, and overly controlled individuals who carefully avoided affect-laden experiences. Their life-style featured ambivalence, doubting, isolation, and rigidity. Denial was often used as a defense; paranoid elements were present though not prominent. One might expect a heightened level of aggressivity in these patients because of the harsh and rejecting attitudes of their parents, separation in their early years, frequent outbursts of anger, their characteristic defenses, and psychological test results. Examinations for neurological disorders revealed no problems.

Homosexual behavior was not a factor in these patients. Meaningful heterosexual relationships were limited by the pursuit of asceticism, the avoidance of affect, and pathological egocentrism. These subjects formed a special type of relationship that was both symbiotic in nature and devoid of meaningful affect. Their need for the object was clearly evident in their desperate attempts to restore an aborted relationship but they either used and dominated the partner or became the passive member themselves, either of which leads to an empty dyadic situation. At times the subject alternated between feeling omnipotent and servile.

In studying these patients, we found four areas that revealed important information on how they coped with stress: 1) the relationship of the religious delusions to their defenses, 2) the influence of the counter culture, 3) the role of meditation, and 4) the meaning of the symbiotic phenomena found in these cases.

RELIGIOUS DELUSIONS AND DEFENSES

Freud (3) and later clinicians (4–6) identified hostility and rivalry as central features of the religious delusions of their patients. Rokeach (2) and recently Perry (7) found that patients with religious delusions were searching for support, protection, a stable identity, and a sense of power. Although our subjects exhibited all these features, we found that their struggle against aggressive urges was paramount. These patients were aided in their struggle by an identification with Christ, who they believed had accomplished a superhuman transcendence over man's baser impulses, including a mastery of sexual impulses that was necessary to maintain asceticism. Our patients' image of Christ's stoicism, serenity, and indifference to pain and discomfort aided their repression and isolation; Jesus' practice of forgiving his tormentors strengthened their reaction formation.

The passive-aggressive and defiant images of Christ are other important features that aided our subjects in coping with their aggressive urges. In the final struggle, Jesus presented the image of a powerful and aggressive leader who made a vigorous assault on the establishment. An identification with Christ gave our patients a sense of omnipotence. This is not to overlook other possible reasons for the identification with Christ, such as the need to deny a sexual relationship between their parents and the desire to recreate a father-son relationship. The latter was observed in certain subjects whose identification with Christ's obedience to God was a solution to oedipal conflict and a defense against aggressive urges. However, pregenital features were foremost in our cases, which

would explain why the delusional states invariably followed separation or the threat of separation.

Case 1. A 23-year-old man, quiet, withdrawn, and bearded, became psychotic after leaving home to accept a prized graduate school fellowship at a distant university. His mother had encouraged the move to fulfill her own ambitions. The patient had been raised by a punitive father, now deceased, and a rejecting mother. He had been lonely and withdrawn and clung to his mother.

Upon taking up his new position away from home, the patient felt isolated, abandoned, and rejected. He was aware of a painful longing for home and of strong feelings of hostility toward his mother for having permitted him to go. He submitted a grandiose proposal for a thesis that would "change the world." He was aware of mounting anger, frustration, agitation, and confusion. He began to have the delusion that he was Christ and that he had a prophetic mission to save people. The identification with Christ brought about a state of relaxation and a sense of power, serenity, and identity that were clearly evident upon his admission to the hospital.

INFLUENCE OF THE COUNTER CULTURE

Cultural factors facilitated both the denial and the expression of aggression in these patients, partly through the externalization and displacement of anger onto the establishment. Rejecting society's traditions also led to expressions of passive-aggressive and defiant impulses, of which drug use was only one example. On the other hand, the philosophy of peace and nonviolence strengthened reaction formation in those of our patients who were struggling against aggressive urges. The patients' involvement in Eastern religions added to this and supported obsessive defenses, while the practice of Yoga, Zen, and vegetarianism provided needed compulsive mechanisms and a sense of control and mastery; meditation furthered these ends. In some situations "soft" drugs were used to aid the ego in modulating affect, regulating drives, aiding self-esteem, and promoting socialization. Hallucinogens were generally shunned because of the fear of losing control. Although our subjects received support from the amorphous, accepting, and nondemanding counter culture, they were also threatened by the lack of controls and the fleeting relationships in this hedonistic society. These comments touch only the high points of what is actually a complex cultural phenomenon with a myriad of influences upon its members.

Case 2. A 19-year-old was admitted in an acute schizophrenic state that was marked by withdrawal, a preoccupation with religion, and compulsive meditation. The patient had been abandoned by a girl with whom he had established a crucial symbiotic relationship. He then joined a nearby hippie group and began to use marijuana to "block out reality" and to raise his self-esteem. Heavy marijuana use enabled him to "cool it" in the face of mounting anger at the rejection. He took part in political activity and peace marches and showed extreme bitterness toward the government. These measures were insufficient to stem a growing sense of losing control, and the patient began to sit in the lotus position continuously in an effort to control all thoughts and impulses, as well as grunts, coughs, belches, and flatus. He refused to eat and was hospitalized.

When he did not respond to treatment with tranquilizers, the staff stopped the patient from meditating. This resulted in explosive and violent behavior that ceased only when he was permitted to resume his meditation position and exercises. In the following days, the religious delusions gained predominance as the use of meditation decreased.

THE ROLE OF MEDITATION

All of our patients had more than a casual interest in meditation; five had practiced it frequently for varying periods of time in response to stress. Meditation aided such ego functions as perception and drive modulation, induced muscular relaxation, and limited their mental imagery, ideas, and specific sensory awareness. This modification of perception provided a barrier against distracting stimuli, such as threatening aggressive urges. Exercises concerned with the control of breathing and other motor functions added to the sense of mastery.

Four of the patients who engaged in meditation experienced mystical states that afforded a sense of omnipotence and grandeur and promoted a feeling of being merged with the universe in a kind of symbiotic or "oceanic" union. The concentration of attention on inner experiences by means of meditation and drugs reduced the patients' awareness of differences between the self, objects, and surroundings.

Case 3. A 24-year-old shaggy-haired, bearded, and withdrawn man had finally found a girlfriend, whom he treated in a superior, domineering, and controlling manner. Since his mother had abused and exploited him, he was determined not to be in a vulnerable position again. However, although he went along with the casual sexual behavior of the counter-culture group he belonged to, he was actually deeply hurt by his "wife's" occasional infidelity, which induced profound feelings of rejection and rage in him. As the relationship continued, the patient became subject to episodes of violent impulses, which he attempted to control with the frequent use of marijuana. To this he added regular periods of meditation, which he had previously practiced only sporadically. He moved with his girlfriend to a thinly settled area, where "she would be all mine" and where he could meditate without distraction. He enjoyed a feeling of being "at one with nature, the stars, and the cosmos," and had a mystical experience in which he felt merged and united with the universe. The isolated and untrammeled surroundings were untouched by reality and favored the development of grandiose fantasies that evolved into religious delusions with messianic content.

SYMBIOTIC AND MERGING PHENOMENA

Recent years have brought a growing conviction among investigators that a high level of activation of aggressivity is a major etiological factor in schizophrenia (8–11). At the same time, the important role of symbiotic relationships and merging phenomena in the schizophrenic's management of aggressive impulses has become fairly well recognized (10–13). Theoretically, the schizophrenic attempts to preserve the object of his ag-

gression by merging with it, but he must not go too far for fear of annihilation. This formulation accounts for the special symbiotic relationships that our patients formed. While they were symbiotic in nature, they were "hollow," since the patient's emotional involvement was limited. At the same time they were necessary to his existence since separation from the object of the relationship provoked panic; a desperate attempt to reestablish the symbiotic relationship with the object, a real substitute, or an imaginary one; and, finally, breakdown. The substitution of an imaginary person was important since the union with Christ represented the reestablishment of a close tie, but with an idealized person.

Case 4. A 20-year-old hippie was admitted to the hospital in an acute schizophrenic state that included the delusion of being Christ. His mother had suffered recurring depression and his father had been cold, aloof, and hypercritical. His only sibling was a shy, introverted brother, one year younger, whom the patient had dominated and intimidated throughout childhood. The patient had felt jealous of his younger brother and had often beaten him up, for which he felt a great deal of guilt. In adolescence he gained control over these violent impulses and formed a close attachment to the brother, who accepted his protective attitude with relief. The relationship was a symbiotic one, but there was very little genuine affective interaction.

The first separation occurred when the patient went away to college at age 18. He felt lonely, confused, and anxious and soon lost interest in school. He began to move within a counterculture group and became preoccupied with religion, mysticism, and drugs. Only when the patient returned home some months later did he focus his energies constructively and obtain a job.

The following September the younger brother went away to college and the patient once again became disorganized. He eventually joined his brother, roomed with him, audited his classes, and read with him in the library while the brother studied. The reestablishment of a close relationship caused the symptoms to disappear. A few months later the brother found a girlfriend and moved in with her. The patient soon felt a mounting fury and expressed the conviction that "the universe was coming apart." He developed the delusion that he was "Jesus Christ, the Messiah" and began to act accordingly. Although the patient's anger disappeared, his bizarre religious behavior led to his hospitalization.

SPECIAL TREATMENT CONSIDERATIONS

Three main factors have to be considered in planning treatment for these patients: 1) the problems of the acute schizophrenic episode, 2) the chronic schizoid and narcissistic personality, and 3) the symbiotic, emotionally empty relationships that these patients formed.

The acute schizophrenic symptoms generally respond to treatment with psychotropic drugs, especially the phenothiazines, although the response may be delayed. The goal of making the religious delusional system less rigid is important since compulsive activities, such as the continuous reading of Bibles, the recording of grandiose thoughts, and meditation, provide formidable resistances. The patient successfully avoids involvement with staff, other patients, and activities when he is in these states of preoccupation. On the other hand, one has to be careful in forcing the removal of such compulsive activities since they may be serving a vital function for a failing ego (14).

Once the patient is ready for expressive forms of therapy, both group and individual approaches are useful. The initial need is to deal with these patients' acute panic states and strong destructive impulses, as well as to establish rapport and trust, qualities that will be useful in the later attempt to repair the underlying chronic personality disorder. This attempt requires confrontation of the profound feelings of loneliness, inadequacy, frustration, and despair that the patient is trying desperately to avoid.

A frequent barrier to interaction with these patients is the demeanor of piety, saintliness, helplessness, and martyrdom that grows out of the religious delusion itself. The result is that the staff may feel guilty or sympathetic toward the patient, unknowingly show him the respect they would show a cleric, or shy away from the aggressive approach that is required to reach out to a seclusive patient and to set limits on a defiant one. In this way the staff lends reality to the patient's grandiose delusional system. The other patients quickly sense and resent the favoritism; they avoid the patient too. Their repressed anger may cause grotesque fantasies about "that withdrawn monk" or "homicidal patient," who usually ends up isolated in a private room.

The chronic personality disorders of these people are difficult to change since they often arise from defects in primitive ego functioning. Due both to the practical considerations of time and means and to the patient's limited capacity for relationships and frustration, it is wise to settle on realistic goals rather than "total cure." During the acute psychosis, these patients may be poorly motivated for therapy; once the acute symptoms are relieved they may be even less motivated. Basic realistic goals for therapy include helping the patient understand the precipitating factors of his illness (such as separation or drugs), making the patient aware of his strong destructive urges, and encouraging his continuing reliance on the therapist as an auxiliary ego, even if the treatment must proceed on an irregular basis because of the patient's frequent need to interrupt.

The symbiotic syndrome demonstrated by some of our patients requires special treatment. The symbiotic psychosis, as it occurs in adulthood, usually features a strong closeness and interaction with the object of the relationship and ambivalence toward it, both a need for and a fear of fusion, a fluctuating sense of differentiation, periods of withdrawal and isolation, and finally a regression to overt schizophrenia when separation occurs. Clinicians who have reported on the treatment of these cases (13, 15–17) have generally dealt with less regressed patients than ours. Limentani (13), for example, noted that his patients searched for a strong figure in reality (often the therapist) with whom to establish a new symbiotic identification upon separation from the object. Our patients accomplished this restoration with a delusional figure, Christ. The treatment methods used by other clinicians, which involve the restoration of the symbiosis in the course of the transference followed by its analysis and resolution, by "desymbiotizing" or by a "corrective

emotional experience," could not be directly applied to our subjects.

When our patients were in the "fixed" state of religious preoccupation, psychotropic medication was the treatment of choice. As they began to improve, this state was replaced by one of continued withdrawal and depression or by one of superficial amiability and conformity that masked an underlying distrust and denial of illness. These represented postsymbiotic "objectless" states and medication was less effective at this point. The high degree of emotional shallowness, intellectualization, grandiosity, and distrust of "the establishment," including doctors, also made a meaningful therapeutic relationship difficult to maintain. However, if the therapist and staff continue to provide needed ego functions, such as a sense of identity, impulse control, and support, while tenaciously attempting to prevent avoidance and withdrawal, patients often form new relationships. These are invariably with nonprofessional staff members or nurses, with whom the patient feels less inadequate and less threatened. These relationships clearly reflect the patient's psychopathology and come to provide needed motivation and focus for continued psychotherapy. Skill is required in treating these patients since there are rapid oscillations in distance-taking and mood, during which the patient frequently experiences abrupt and intense hostility. The hostility can be expressed in suicidal or homicidal states that call for careful management.

Finally, in certain cases, a relative of the patient can be profitably involved in treatment. When the patient is not too distrustful, the family member can be encouraged to resume or to form a symbiotic relationship under the guidance of the therapist. In this manner the father of one subject and the brother of another served as "back-up therapists." This prevented regression at times when contact with the therapist was interrupted by the patient. In these instances, subsequent resumption of therapy was largely due to the urging of the family member.

REFERENCES

1. Roszak T: The Making of a Counter-Culture. New York, Doubleday, 1969
2. Rokeach M: The Three Christs of Ypsilanti. New York, Vintage Books, 1964
3. Freud S: Psychoanalytic notes on an autobiographical account of a case of paranoia (1911), in Complete Psychological Works, standard ed, vol 12. Translated and edited by Strachey J. London, Hogarth Press, 1958, pp 3–82
4. Kaufman MR: Religious delusions in schizophrenia. Int J Psychoanal 20:363–376, 1939
5. Lowe WL: Group beliefs and sociocultural factors in religious delusions. J Soc Psychol 40:267–274, 1954
6. Boisen AT: Religion in Crisis and Custom: A Sociological and Psychological Study. New York, Harper, 1955, pp 54–63
7. Perry JW: The messianic hero. J Anal Psychol 17:184–198, 1972
8. Pious WI: The pathogenic process in schizophrenia. Bull Menninger Clin 13:152–158, 1949
9. Hartmann H: Contributions to the metapsychology of schizophrenia. Psychoanal Study Child 8:177–197, 1953
10. Bak RC: The schizophrenic defense against aggression. Int J Psychoanal 35:129–134, 1954
11. Kernberg O: Borderline personality organization. J Am Psychoanal Assoc 15:641–685, 1967
12. Searles HF: Data containing certain manifestations of incorporation. Psychiatry 14:397–413, 1951
13. Limentani D: Symbiotic identification in schizophrenia. Psychiatry 19:231–236, 1956
14. Horton PC: The mystical experience as a suicide preventive. Am J Psychiatry 130:294–296, 1973
15. Pollock GH: On symbiosis and symbiotic neurosis. Int J Psychoanal 45:1–30, 1964
16. Shapiro DA: Symbiosis in adulthood. Am J Psychiatry 129:289–292, 1972
17. Rinsley DB: A contribution to the nosology and dynamics of adolescent schizophrenia. Psychiatr Q 46:159–186, 1972

Opinions About Mental Illness and Political Ideology

BY ALEXANDER TOLOR, PH.D.

The author examines the relationship between attitudes toward mental illness and psychiatric patients on the one hand and reactions to the withdrawal of Senator Thomas Eagleton as a candidate for Vice-President on the other. A sample of 384 undergraduate college students was surveyed with the Opinions about Mental Illness (OMI) scale and a specifically devised political ideology scale. The results indicated that OMI factor scores were substantially related to political views.

THE 1972 PRESIDENTIAL ELECTION afforded those in the mental health field who are interested in evaluating public attitudes toward the emotionally disturbed a unique

An abbreviated version of this paper was presented at the 44th annual meeting of the Eastern Psychological Association, Washington, D.C., May 3–5, 1973.

Dr. Tolor is Research Professor of Psychology and Director, Institute for Human Development, Fairfield University, 611 North Benson Rd., Fairfield, Conn. 06430.

opportunity to investigate these attitudes in relation to political views. The withdrawal from the Democratic ticket of Senator Thomas Eagleton raised many questions about the appropriateness of the decision as well as the presumed negative attitude of the American voter toward the emotionally disturbed. In fact, the disclosure of Senator Eagleton's psychiatric history, including his experience with electroconvulsive therapy, captured the attention of the nation as very few mental health events had previously and prompted many people to focus on the possible impact of emotional problems on the future functioning of a nationally prominent figure. The "dumping" of Senator Eagleton produced a great variety of reactions, ranging from total agreement to complete disagreement with the decision. It may be presumed that individual differences in reactions were based at least in part on different views toward the emotionally disturbed.

I took advantage of these circumstances by conducting a survey to determine more precisely whether attitudes toward mental illness were related to people's views of the Eagleton decision. Moreover, the study attempted to ascertain whether specific aspects of people's attitudes toward mental illness distinguished between political orientations, voting preferences, and opinions on whether those with a history of emotional disturbance should hold high office.

METHOD

Subjects

The survey was conducted with 384 undergraduate college students ranging in age from 17 to 39 years, with a mean age of 18.7 years (standard deviation = 1.62). This sample therefore consisted primarily of a group of youthful voters, most of whom had only recently become eligible to participate in the national elections. In the sample, 61 percent were men and 39 percent were women; racially, 97 percent were white. In terms of class year, 59 percent were freshmen, 17 percent were sophomores, 14 percent were juniors, and nine percent were seniors.

Procedure

Each of the participating subjects was administered a questionnaire booklet containing a demographic data sheet, an eight-item political ideology scale, and the 51-item Opinions about Mental Illness scale (OMI) developed by Cohen and Struening (1). The political ideology scale dealt with reactions to the Eagleton affair, i.e., with whether the decision was regarded as being correct and whether Senator Eagleton's withdrawal adversely affected the respondent's outlook on politics in general or the party more specifically. One item asked whether someone with a history of previous emotional problems should be considered for high office; another item requested information on voting preference. Except for the last question, all items called for a "yes," "no," or "undecided" response. The items of the scale are presented in appendix 1.

The Opinions about Mental Illness scale (OMI) is based on the assumption that opinions about the psychiatrically disturbed are potentially multidimensional; these dimensions are considered to be identifiable through multiple-factor analysis. The OMI contains Likert-type items that have been demonstrated by Struening and Cohen (2) to have factorially stable scores on five dimensions of attitudes toward mental illness. Each of the component items is scored in the direction of its positive or negative factor loading.

The five salient OMI dimensions underlying opinions about serious emotional disturbance and mental patients are designated as authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal etiology. Each of these has a specific conceptual meaning within a multidimensional context. For example, authoritarianism stresses the different and inferior status of mental patients; benevolence involves a kind, paternalistic view of patients, based on a religious or humanistic philosophy; mental hygiene ideology involves the endorsement of the views of mental health professionals; social restrictiveness embraces the notion that patients and former patients are socially dangerous; and interpersonal etiology considers mental illness to be grounded in interpersonal experiences, particularly deprivation of parental love during childhood.

Testing was done in small groups approximately four to five weeks before the November 7, 1972, election.

RESULTS

Overall Descriptive Data on Political Ideology Scale

Seventy percent of the respondents thought that the way in which Senator Eagleton had been treated by the Democratic Party after the disclosure of his psychiatric history was not essentially correct.

Although 83 percent thought Eagleton should have revealed his former emotional difficulties immediately upon being offered the Vice-Presidential nomination, 61 percent asserted that they had become more discouraged with the entire political process and 63 percent reported that their voting preferences had undergone a change because of the events surrounding Eagleton's nomination and subsequent forced withdrawal. Despite the disillusionment of a majority of respondents, only 13 percent indicated that their desire to cast a vote had diminished because of these circumstances.

A significantly ($\chi^2=4.97$, $p<.05$) higher proportion of students who identified themselves as Democrats than those who identified themselves as Republicans indicated a change in their voting preference because of the Eagleton affair (77 percent for Democrats versus 65 percent for Republicans). Moreover, there were significant differences ($\chi^2=7.23$, $p<.01$ and $\chi^2=15.75$, $p<.001$, respectively) between students who professed to be Democrats and those who professed to be Republicans as to whether dropping Eagleton was a proper course of action (45 percent of the Republicans and 28 percent of the Democrats agreed) and as to whether a previous emotional distur-

TABLE 1

Comparison of High and Low Scorers on the Five OMI Factors According to Differentiating Items of the Political Ideology Scale, in Percentages

Differentiating Items	High Scorers			Low Scorers			X^2	Significance
	Yes	No	Undecided	Yes	No	Undecided		
Authoritarian factor								
The way Eagleton was handled was correct.	19	65	16	19	77	4	15.70	p<.001
Eagleton's forced withdrawal caused my discouragement with the political process.	55	35	10	67	28	5	7.00	p<.05
My desire to vote diminished because someone with a history of emotional problems was asked to withdraw.	10	81	9	19	75	6	7.88	p<.02
My voting position was not changed by the events surrounding Eagleton's withdrawal.	64	23	13	61	32	7	8.28	p<.02
A psychiatric history makes someone a poor risk for political office.	43	25	32	28	44	28	17.14	p<.001
Benevolence factor								
The way Eagleton was handled was correct.	25	65	10	14	76	10	8.20	p<.02
Eagleton's forced withdrawal caused my discouragement with the political process.	57	37	6	65	24	11	8.89	p<.02
Mental hygiene ideology factor								
Eagleton's forced withdrawal caused my discouragement with the political process.	68	27	5	53	34	13	11.30	p<.01
My desire to vote diminished because someone with a history of emotional problems was asked to withdraw.	18	75	7	9	82	9	7.41	p<.05
A psychiatric history makes someone a poor risk for political office.	31	43	26	41	23	36	17.96	p<.001
Social restrictiveness factor								
The decision to drop Eagleton as a candidate was proper.	39	42	19	34	55	11	7.49	p<.05
A psychiatric history makes someone a poor risk for political office.	41	25	34	32	42	26	12.81	p<.01
Interpersonal etiology factor								
Eagleton's forced withdrawal caused my discouragement with the political process.	63	33	4	58	29	13	8.76	p<.02

bance made someone seeking high office a poor risk (49 percent of the Republicans and 27 percent of the Democrats agreed).

Relation Between OMI Factors and Political Ideology

To determine whether differences in attitudes toward the mentally ill were related to responses to the political ideology questions, subjects were first divided into high scorers (above the median) and low scorers (below the median) on each of the five OMI factors. The results indicated that a substantial relationship between factor scores and political views did indeed exist. Of the 40 chi-square analyses, 17 yielded differences significant at the level of .05 or better.

As can be seen in table 1, those whose scores for authoritarianism were high differed significantly from those whose scores were low: they indicated less often that the Eagleton affair was handled incorrectly but more often expressed uncertainty about their reaction to its handling, less often reported discouragement with the political process, indicated less often that the Eagleton affair had diminished their desire to vote, less often changed their preference for a candidate, asserted more often that a person with a history of psychiatric illness is a poor risk, and were more often affiliated with the Republican Party (among high scorers, the preferences were Democratic=19 percent, Republican=50 percent, other or none=31 percent; among low scorers, the party preferences were 40 percent, 34 percent, and 26 percent, respectively; $\chi^2=20.98$, $p<.001$).

Respondents with high benevolence scores differed from those with low scores: they more often stated that the Eagleton situation was handled properly, less often reported disillusionment with the political process, and more often preferred the Republican position (among high scorers, the preferences were Democratic=26 percent, Republican=47 percent, other or none=27 percent; among low scorers, the party preferences were 33 percent, 35 percent, and 32 percent, respectively; $\chi^2=6.26$, $p<.05$).

Those with high mental hygiene ideology scores differed from those with low scores by being more often discouraged by the political process, having more often lost their desire to cast a vote, less often considering a psychiatric illness to make a candidate a poor risk for high office, and being Democrats relatively more often than Republicans (among high scorers, the preferences were Democratic=37 percent, Republican=43 percent, and other or none=20 percent; among low scorers, the party preferences were 22 percent, 40 percent, and 38 percent, respectively; $\chi^2=16.49$, $p<.001$).

Subjects with high social restrictiveness scores differed

from those with low scores: they felt relatively more often that the dumping of Eagleton was proper, more often regarded a person with a history of psychiatric illness as a poor risk for high office, and indicated relatively more often that they were Republicans (among high scorers, the preferences were Democratic=25 percent, Republican=43 percent, other or none=32 percent; among low scorers, the party preferences were 36 percent, 40 percent, and 24 percent, respectively; $\chi^2=6.55$, $p<.05$).

High scorers on interpersonal etiology differed from low scorers by showing less uncertainty in relating the Eagleton situation to a growing disillusionment with politics.

DISCUSSION

Although the group trends were not of sufficient magnitude, despite their statistical significance, to permit making individual predictions, the results indicated that attitudes toward the emotionally disturbed do show a general association with political beliefs. More specifically, the configuration of beliefs that includes stressing the different and inferior status of mental patients (i.e., a high score on authoritarianism), the rejection of the philosophy that is characteristic of mental health professionals (i.e., a low score on mental hygiene ideology), and the view that mental patients and former patients are dangerous to society (i.e., a high score on social restrictiveness) tended to be related to a Republican voting preference, a belief that a history of emotional disturbance should disqualify a candidate from serving in high office, a more favorable attitude toward the political process, and a greater desire to maintain the status quo. All of these results are consistent with the conceptual meaning assigned to the OMI factors.

The one surprising set of relationships was found in the benevolence factor. Those who took a kindly and paternalistic view of patients, on the basis of religious or humanistic ideologies, tended often to be Republican and also favored the Eagleton decision relatively more often than those who took a less kindly and paternalistic view of patients. It is possible that some of the people who had high benevolence scores perceived the dropping of Eagleton from the ticket as being in his best interest by sparing him extra responsibilities and undue stresses. In any case, it should be noted that the majority of both high and low scorers on the benevolence factor felt that the way in which the Vice-Presidential nominee had been handled was not correct.

The survey also suggested that in this group of young, recently enfranchised voters, McGovern's chances of winning the Presidency were seriously undermined by the Eagleton affair. In view of the general consistency between political and mental health views, it is apparent that a candidate who is known to have had major adjustment problems will evoke very different reactions in people of different political persuasions.

REFERENCES

1. Cohen J, Struening EL: Opinions about mental illness in the personnel of two large mental hospitals. J Abnorm Soc Psychol 64:349–360, 1962
2. Struening EL, Cohen J: Factorial invariance and other psychometric characteristics of five opinions about mental illness. Educational and Psychological Measurement 23:289–298, 1963

APPENDIX 1

Items of the Political Ideology Scale

For the first seven questions, the subjects were asked to respond "yes," "no," or "undecided." On the last question, they were asked to indicate their political preference.

1. The decision to drop Senator Eagleton as a Vice-Presidential candidate was a proper one.
2. The way in which Senator Eagleton was handled by those in control of the Democratic Party, after the disclosure of his psychiatric history, was essentially correct.
3. Senator Eagleton should have revealed to Senator McGovern his psychiatric history as soon as he had been offered the Vice-Presidential candidacy.
4. The forced withdrawal of Senator Eagleton from the Democratic ticket caused me to become discouraged (or more discouraged) with the political process.
5. My desire to cast a vote has diminished because of the fact that a candidate with previous emotional problems was asked to withdraw.
6. My position concerning the Presidential candidate I will vote for has not changed because of the events revolving around Senator Eagleton's nomination and subsequent withdrawal.
7. A person with a history of emotional problems is usually a poor risk for serving in high office.
8. At this time, my voting preference is: Democrat, Republican, undecided or none.

EDITORIAL

The Psychiatrist and Family Planning

INDIVIDUAL PSYCHIATRISTS, in concert with fellow mental health workers, colleagues in allied disciplines, and concerned citizens in the United States and abroad, are becoming increasingly aware of the complex societal and personal issues embedded in questions of human fertility and population. They are sensitive to the impact of unrestricted population growth upon our fragile biosphere and the quality of life it can sustain. At the same time they deeply feel their responsibility as clinicians concerned with the ethical, compassionate, and humane care of individuals and their families.

The American Psychiatric Association has been cautious in making an organizational approach to these questions. Its recent action, however, of appointing a Task Force on Psychiatric Involvement in Family Planning recognized the key roles played by some members of the psychiatric profession in assisting individuals and families to make the difficult choices about whether or not to practice contraception, terminate pregnancy, or preclude its occurrence on a permanent basis. It also opens the door to more systematic exploration of the problems confronting psychiatrists in the difficult borderland between individual and societal rights and responsibilities.

An initial need is to define and clarify some of the issues involved in this broad area. Family planning and formation are activities of individuals. Good family health is good mental health (1). Population planning, on the other hand, is a policy activity of governments and other societal institutions. This distinction has been implied by the World Health Organization: "Family planning is a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples . . ." (2). Informed, responsible decision making requires knowledge and readiness to accept or reject parenthood and family tasks. Yet the two kinds of activities, policy and personal, cannot always be clearly separated since individual decisions are made in a context of information, facilities, and constraints influenced by governmental and other institutional actions.

Major fertility-related decisions may be sexual, conceptive (proceptive or contraceptive), abortion-seeking, or procreative (3). They may lead to the use of specific procedures or techniques. Any new fertility-regulating method, like any biomedical advance, is effective only insofar as the utilizer—the individual human being—is able to make the necessary choices about its use in relation to others in his social environment. And a major component in this decision-making process is the quality of the interaction between service utilizers and service providers.

Family planning also has consequences that are not well defined. These include the social, psychological, and adaptive effects of particular decisions.

Psychiatrists have a responsibility to be professionally concerned with the psychosocial determinants and consequences of family planning. Their current involvement reflects a number of overlapping roles and capacities.

First, as members of a mental health profession, they depend on expertise derived from their training and experience in individual, family, and group dynamics and therapies. They may work with individuals who come seeking help or counsel or with insti-

In this section the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

tutions and agencies concerned with family planning, sex education, and other fertility-related matters.

Second, as medical specialists they are concerned with the psychosocial components of bodily change. They may be consulted, for example, about mental health aspects of infertility, sterilization, and abortions. They also carry responsibility for the mentally handicapped, including the hospitalized mentally ill and retarded. Family planning counseling and practice for these groups requires special attention to the legal and ethical aspects of fertility regulation in persons whose capacity for responsible decision making is uncertain. Moreover, as a physician the psychiatrist has access to social influence, which allows him (if he wishes) to be an agent of social change and to facilitate the acceptance of public health measures, including family planning programs.

Third, psychiatrists may function as behavioral scientists, often in association with colleagues from other disciplines. In this capacity a number are already involved in research on the psychological, social, and cultural determinants of fertility-choice behavior at different phases of the human sexual-reproductive career, on the acceptability of specific procedures, and on fertility regulation among the mentally handicapped.

Interdisciplinary and interprofessional collaboration are essential to family planning service, education, and research. Physicians, including psychiatrists, require information and guidance both to reduce indifference and to enhance the idea that family planning should become part of general health care. Since the bulk of family planning services (including personal counseling) in the United States and abroad will be carried out by indigenous workers, the education, training, and development of these workers must also be a major concern.

Man's imperfect but increasingly powerful ability to manipulate his own biological destiny and fertility present him with challenges and conflicts whose magnitude is only slowly being faced. Explicit attention to what many regard as an inviolable area of self-determination is often experienced as frightening (4). It is time for psychiatrists to heighten their sensitivity to evolving psychosocial concerns related to human fertility; in this way they may contribute to enhancing the quality of life for present as well as future generations.

REFERENCES

1. Group for the Advancement of Psychiatry: Humane Reproduction. Report 86. New York, GAP, 1973
2. World Health Organization: Health Education in Health Aspects of Family Planning. Technical Report Series 483. Geneva, WHO, 1971
3. Miller W: Conception mastery: ego control of the psychological and behavioral antecedents of conception. Comments on Contemporary Psychiatry 1:157–177, 1973
4. Brody EB: The social control of human reproduction: some policy aspects of fertility-regulating behavior. Ment Hyg 1973 (in press)

EUGENE B. BRODY, M.D.

Dr. Brody is Professor, Department Chairman, and Director of the Institute of Psychiatry and Human Behavior, University of Maryland School of Medicine, Baltimore. He is also Chairman of the APA Task Force on Psychiatric Involvement in Family Planning, whose other members include Robert Cancro, M.D., Stephen Fleck, M.D., James Lieberman, M.D., Warren Miller, M.D., and Lane Ameen, M.D. (ex officio). Consultants are Henry P. David, Ph.D., Zigmond Lebensohn, M.D., Lucile Newman, Ph.D., and M.C. Shelesnyak, Ph.D.

BRIEF COMMUNICATIONS

What Is Psychiatry? A New Model of Service and Education

BY ALEXANDER Z. GUIORA, PH.D., AND SAUL I. HARRISON, M.D.

The authors review the history of mental health models as well as related systems of professional education and service delivery. The current situation is criticized as being too concerned with professional privilege and hierarchies while seeming to ignore both gaps in and duplication of services. The authors therefore suggest the need for more organizational paradigms for the mental health field; these are to be derived rationally from the community's needs and the expanding knowledge pool. To the authors this suggests a system of hierarchical education based on career steps that could be entered at various levels of competence and certification.

GEORGE ENGEL (1) recently posed a troubling question in the pages of this journal: Is psychiatry failing in its responsibilities to medicine? Although we would agree with most of the points made in his necessarily brief answer, we have found what he omitted to be disquieting. Obviously, editorials are not meant to be comprehensive; nevertheless, additional observations leading to broader recommendations seem vital for any serious assessment of the role of psychiatry today.

The issues we wish to stress here stem from a contemplation of the broad field of mental health as it has been affected by changing conceptual models and a growing imbalance between its systems of education and service delivery.

CHANGING CONCEPTUAL MODELS

The mental health professions have witnessed a cyclic ascent and decline of three conceptual models—biological, psychological, and social. We have seen mode after mode of intervention reach prominence and then be discarded because it fails to live up to its promises, only to rise and fall once again. We have known the arid years of hopelessness when there was only a rather primitive biological model. Following that we witnessed the spectacular rise of a psychological model—psychoanalysis—only to watch it decline in prestige. As the psychological model recedes, an upsurge of hope and activity is now centering on the biochemical field. In between came short-lived social models that never really blossomed except as an interlude between the two. We had the child guidance clinic movement in the 1920s, and the final judgment has not yet been made on the community mental health movement of the 1960s. Neither do we have sufficient distance yet to talk objectively about the resurgence in the 1960s of the behaviorism that was hailed in the 1920s.

Perhaps this sense of déjà vu has a vital lesson to teach us. The succession of conceptual models in the mental health field may mean that the essential human needs to which the field has contracted to minister have not yet been precisely identified. We currently conceive of such needs in terms of the familiar disease model. We try to minimize the vague discomfort we feel about its inadequacies by attaching qualifiers. Thus we speak at times of psychological illness, or organic illness, or social illness. What we neglect are those essential needs to which we as a field are not responding—the existential anxiety that attends upon human existence itself.

True, people get sick and specific remedies may exist. True, people get tangled up in psychic conflicts that psychotherapy may unravel. True, society impinges on the individual, and attention to the interfaces can give the individual relief. But these are not the whole story.

There are many who say that we mental health professionals have inherited a legacy that was never meant for us. Though we have never disclaimed the inheritance, we seem strangely unable to recognize its true nature, let alone to use it properly. We have in fact inherited the vacuum in which faith and belief, a priesthood and an all-inclusive value system—the Church—once held sway. Although we were unable to extend the same comforts in time of existential need, were unsure of our power of ab-

Dr. Guiora is Professor of Psychology and Dr. Harrison is Professor of Psychiatry, Department of Psychiatry, University of Michigan Medical School, Ann Arbor, Mich. 48104.

The advice of John Hartman, Ruth Marquis, and Jules Schrager is gratefully acknowledged.

solution and the certainty of salvation, and were clearly without a divinity or a divine dogma, we took on the mantle of priesthood. We have recast the existential needs into more familiar and less threatening medical terms. But alas, magic does not work on the nonbeliever. Renaming the central need has not changed it. We have only fortified an endless cycle of hope and despair.

Secondly, we need to consider how we in the mental health field organize the way we educate and certify. To continue with the priestly paradigm, we have become laden with esoteric knowledge and wisdom and privilege—all of which are of minimal use in the actual delivery of the service we have designed. One might say that we have formed a priesthood of learning and privilege, with elaborately separated orders. There are the orders of psychiatrists, psychologists, social workers, and other ministrants. Each order has its own set of hard-won privileges and is surrounded by hermetically sealed boundaries. Each order—in its quest for greater excellence, we presume—heaps layer upon layer of knowledge (or at least information) on the aspiring novice, who will ignore, it is hoped, all the overlap, duplication, and sheer waste.

By now, any effort to delineate the mental health professions forces our attention toward the overlapping, shared, and duplicated roles and functions among them. Indeed these common functions may exceed what is truly unique about the separate professions. For example, the increasingly minimal distinctions between some psychiatrists and some clinical psychologists suggest less than rational horizontal and vertical patterns of expertise or specialization. Examination reveals to how small an extent the supposed distinctions between the professions bear any sensible relation to community needs, to the shared knowledge pool, to a planned system for delivering service, or to our system of education.

THE BASIS OF DISTINCTIONS

Change has been rapid in the mental health professions and their scholarly disciplines. Education for the clinical psychologist has become more and more professionalized, and the education of physicians has been scholarized. Thus, "tradition" is no longer enough to explain the distinction between professions. By now it is politics, elitism, economics, and other self-serving internal dynamics of the professions that determine their boundaries.

Disturbing and radical as it may seem, should we not seriously consider the advantages and disadvantages of realigning professional designations in the mental health field? Should we not base professional distinctions on the realistic functions and roles that are needed instead of on factors unrelated to current and future needs? Shouldn't those needs be the ones to determine our service delivery system and how we educate people to prepare for it? And might this not lead us to reexamine and perhaps redefine the very meaning of the word "physician"?

To understand our present problem we need to ask where the elitism of physicians began. The concepts of professionalism proposed by Flexner (2) have had a lasting effect on medical education and very likely on other professions as well. Among the legacies to medicine that accompanied Flexner's goal of higher quality was a tendency toward elitist exclusionism. It is true that the pre-Flexner period was marked by less than adequate professional preparation—diploma mills, short courses, incomplete night schools, and other minimally adequate training procedures. Nevertheless it enabled many to practice medicine and resulted in an adequate supply of physicians, although too many had dubious qualifications.

Today medical education and most other professional education aims primarily, if not exclusively, at preparing only the highest level professional. The claim that it is for the protection of the public is a valid justification but there is the unfortunate by-product that too much of the public has no access to the high-quality professional—a circumstance which suggests that our present educational arrangement is not based on any rational correlation between recognized needs and available knowledge. Instead we follow the apparently unassailable dogma that the better the professional's education, the better the service he will render.

In theory this can hardly be challenged. But what evidence do we have that the intensive preparation pediatricians receive for diagnosis and treatment of the complex problems they encounter in pediatric training centers has improved either the quality or quantity of service they render for the respiratory infections, eating problems, and enuresis so commonly encountered in the community? This need for relevant training is even more important in the case of preventive work in the psychosocial areas of pediatrics.

To consider another area, is there any evidence that the increasing professionalization of nursing has improved the quality of nursing care delivered to the hospitalized patient? Although a doctorate in nursing may advance the profession's development, what effect does it actually have on the quality or quantity of nursing care delivered? Nursing developed to help the physician, whose techniques and areas of knowledge were expanding and growing more complex. The physician now requires the help of secondary professions such as nursing, social work, physical therapy, and inhalation therapy. Nursing, like all other professions, has created its own narrow vertical career ladder. But why can't the members of the secondary medical professions have access to a horizontal form of advancement on the career ladder? Why can't a nurse become a physician by building on what he or she has already accomplished? Why can't there be an interlocking system of permeable hierarchies?

The issue before us, then, is this: Should professional education be based on a series of vertical career steps in the hierarchy? The military has a medical support system founded on just such a hierarchy. The levels of expertise include the general duty corpsman, the specialized corpsman technician (e.g., operating room technician, psychiatric technician), and those capable of independent duty. People from these secondary ranks provide a major

source of the physicians' assistants in civilian life after they have completed their tours of duty. Perhaps this method of ordering medical care stems from the mission of military medicine, which is so unambiguously and narrowly defined that typically it does not need to concern itself with people's existential demands—only with the needs of the system.

In civilian life, by contrast, the mental health professions often promise far more than they can deliver. Worse, we seem to be promising a response to demands from the individual and society that are actually in conflict. Ultimately the individual wants relief from his existential anxiety, whereas society wants us to ensure that the individual is under social control.

THE NEED FOR A NEW PARADIGM

Many of these concerns have been expressed by others and have resulted in proposals to remedy the problems of both our own and other health fields. Comparable bold and broad-sweeping suggestions regarding the delivery of obstetrical services were articulated by Willson in his 1970 presidential address to the American College of Obstetricians and Gynecologists (3). Lawrence Kubie, considering the problem of overlap among mental health professions, has suggested that elements from the training programs of psychiatrists and psychologists be combined to form a new profession of psychotherapy (4–6). In 1971 the proceedings of a conference devoted to psychotherapy as an autonomous profession were published (7). More recently, Abroms and Greenfield (8) have suggested that we might resolve some of the problems of the current practice of psychotherapy if we were to teach and then license nonmedical psychotherapists to dispense drugs. Still others respond to the need for expanded services by recommending bringing into the delivery network the nonprofessional workers whose professional training may be less than that of other mental health workers, but whose expertise is forged by their own life experience.

All these approaches have merit, but none is conceived broadly enough to resolve the many facets of our dilemma. A bold design would call for revamping the whole system. Such a design would use elements of the Kubie model for the creation of a unitary profession. It would also incorporate the spirit behind the paraprofessional movement so that mental health careers could be entered at varying levels of competence and certification.

If one were to establish a system of hierarchical education based on such career steps, it might be wise to make it a complete system from top to bottom. The recent and sometimes violent confrontations between professionals and those in the newly established roles of indigenous paraprofessionals point up the need for this. Such an interlocking system of more accessible hierarchies should also begin training people at a younger age. It should have points of entry all the way to the top and should define the "lower" levels not only as more limited steps on the career ladder (which has a negative connotation) but also as more specialized ones (which has a more positive ring).

The current fashion of admiring the Chinese and Soviet systems causes us some constraint in citing them as examples. But in China the "barefoot doctor" has only a few months of formal training. The rural doctors are educated in a year, and they are followed in the hierarchy by the better educated "assistant doctors." In the Russian hierarchy there are the positions of feldsher, physician, specialist, and professor, each calling for additional education. In both cases the guiding principle is that of an interlocking system of permeable hierarchies of competence and certification.

More has been said here of our professional problems of education and delivery of service in mental health than of our other dilemma—the need for a more holistic definition of our existential needs. But perhaps improving the one situation would ameliorate the other. A more rational organization within the professions could one day be reflected in a more rational organization of care. Perhaps by expanding our delivery to include all the people we will one day be challenged to care for the whole human being.

REFERENCES

1. Engel GL: Is psychiatry failing in its responsibilities to medicine? (Editorial). Am J Psychiatry 128:1561–1564, 1972
2. Flexner A: Medical Education in the United States and Canada. New York, Carnegie Foundation for the Advancement of Teaching, 1910
3. Willson JR: Health care for women: present deficiencies and future needs. Obstet Gynecol 36:178–186, 1970
4. Kubie LS: The pros and cons of a new profession: a doctorate in medical psychology. Tex Rep Biol Med 12:692–737, 1954
5. Kubie LS: Need for a new subdiscipline in the medical profession. Arch Neurol Psychiatry 78:283–293, 1957
6. Kubie LS: The school of psychological medicine within the framework of the medical school and university. J Med Educ 39:476–480, 1964
7. Holt RR: New Horizon for Psychotherapy: Autonomy as a Profession. New York, International Universities Press, 1971
8. Abroms GM, Greenfield NS: Drug-prescribing and the mental health professions: a proposal. Int J Psychiatry (in press)

Historical Background in Children with Affective Disorders

BY DONALD H. McKNEW, JR., M.D., AND LEON CYTRYN, M.D.

A study of the histories of 50 children with affective disorders revealed that certain environmental factors were present either singly or in combination in every case. When these environmental factors were related to the three types of childhood depression previously outlined by the authors, each category of depression could be linked with a characteristic cluster of environmental factors; for two of the categories, a specific environmental factor was present in every case studied.

THE EXISTENCE OF AFFECTIVE DISORDERS in childhood, although still a matter of dispute, is gaining increasing acceptance in the literature. One aspect of the matter that causes a great deal of controversy is the etiology of such disorders. People attack this issue from a variety of perspectives, including biochemistry (1), neurophysiology (2), endocrinology (3, 4), genetics (5, 6), and psychodynamics (7–14). Our own research group at the Children's Hospital of the District of Columbia has for the past four years been involved in a study of affective disorders in children from several of these perspectives. In a previous article in this journal we proposed a classification scheme for depression in childhood and briefly reviewed several aspects of childhood depression, including historical background (15).

To date we have seen more than 50 patients with affective disorders, 16 of whom were studied intensively in our research ward. Our examination of these patients' histories has revealed several modes of family interaction and certain types of specific events that occurred singly or in combination in all cases.

In this paper we will attempt to outline these recurring environmental factors and to delineate their relationship to the classification scheme for childhood depression proposed in our previous paper (15).

ENVIRONMENTAL FACTORS

Frequent Separations

A recurrent theme in many of our patients' lives has been frequent separations for periods of several months from important love objects, particularly during the first few years of their lives. For many of these children, it was a grandparent, baby-sitter, or some distant relative who functioned as the major love object in addition to a parent at some point in the child's maturing years. Frequently, episodes of reattachment to the original love object were followed by further separations. The child's substitute caretakers during the time of separation were frequently indifferent to the child or provided an unstable environment.

It is important to stress the fact that this was not the kind of deprivation in which there had never been an attachment to a significant love object or in which the significant object was withdrawn from the child's environment and no reattachment was ever allowed to occur, such as is often the case with chronically institutionalized children.

Sudden Loss

An experience common to many of our patients was the permanent loss of a crucial love object as a result of death, divorce, or a move away from the child's environment, with no further contact. The important factor here seems to be an excessive dependency on the particular loved one before the loss and the absence of any appropriate substitute after the loss. These children often functioned quite well until the loss of the love object.

Depreciation and Rejection

Many of the children we studied have suffered rejection and depreciation by their parents or loved ones either all during their lives or at least over a period of many years. Such rejection may take the form of blunt statements stressing the child's worthlessness or inadequacy, or it may be expressed more subtly through attitudes and actions that indicate a lack of respect, involvement, or caring. In some cases the parent has subjected the child to a constant barrage of criticism and humiliation. In other cases there is no frank rejection or depreciation, but rather a void in the parent-child relationship. The parents may or may not be consciously aware of their behavior.

In some instances this process of depreciation and rejection is related to some obvious characteristic of the child, such as a physical or mental handicap, or his sex, age, or position among his siblings. In other cases the process is much less obvious and requires a good deal of inference and extensive observation of the parent-child interaction to be understood.

Depreciation of the child can be shown through overprotection as well as through rejection; both attitudes convey the same basic message of the child's inadequacy

Both authors are Research Associates at Children's Hospital, 2125 13th St., N.W., Washington, D.C. 20009. In addition, Dr. McKnew is Assistant Clinical Professor and Dr. Cytryn is Clinical Professor of Child Health and Development and Psychiatry, George Washington University Medical School, Washington, D.C.

This work was supported by Public Health Service grant MH-40796 (Research Scientist Award to Dr. Cytryn) from the National Institute of Mental Health and grant RR-284 from the Division of Research Resources, National Institutes of Health.

and worthlessness. How much of the child's subsequent depressive outlook is caused by identification with this negative view of himself and how much is caused by a sense of alienation from important love objects is often hard to determine.

Loss of Involvement

In some situations a central figure in the child's life suddenly withdraws his interest in the child while maintaining a physically intimate presence. Here we are not discussing a noxious interaction with the child (as in the category of depreciation and rejection), but rather the loss of a crucial positive relationship in the absence of alternative love objects. Such a loss of interest on the part of the adult is usually related to such outside events as illness, personal tragedy, a change in involvement with other people (as in the case of remarriage), or a new baby in the home.

Depression in Parents

We found that in many of our cases at least one parent showed clinical evidence of depression. Some had been previously treated for depression. In some parents, however, the depression was manifested as a rather subtle mood disorder that never reached a clinical level requiring treatment.

Parental depression may affect the child either through the child's identification with the parent or through the parent's loss of involvement with the child as a result of his illness. Some children improved rapidly as soon as they were separated from their parents—a phenomenon we frequently observed when a child was hospitalized. This may be attributed to a lack of internalization of the parent's depression. In such cases the child's chronically depressed mood improved within one or two days and recurred only during parental visits. On the other hand, those children in whom the process of internalization seemed to be already operating remained depressed while they were away from their parents. This was true for children as young as six years of age.

DISCUSSION

We wish to stress the fact that we are merely describing historical events that we saw regularly occurring in the lives of our patients; we are not imputing to them any direct etiological significance. The presence of certain recurring environmental factors in our patients' backgrounds does not in any way preclude the existence of a genetic predisposition in some or all cases. Other limiting factors that should dictate caution in interpreting our findings are the relatively small sample, the retrospective method of eliciting historical material, and the lack of reliability of many of our patients' parents. When there is a dramatic, clearly circumscribed event, such as death or divorce, the relationship between such an event and the affective disorder is more easily established. However, many subtle parental behaviors (for example, scapegoating, withdrawal of affection, transient depressive affect) are irretrievable in retrospect as historical events, because of denial or repression of the behavior by the child or parent.

A finding that seems to favor the meaningful relationship between affective disorders and early childhood events is that each of the three types of childhood depression identified in our previous paper (15) can be linked to a characteristic cluster of environmental factors. These three categories of depression included acute depression, chronic depression, and masked depression.

Acute depressive reaction always followed a sudden loss or a loss of involvement. No instances of clinical depression in the parents were found within this category, although there were many instances of subtle mood disorders in the parents. Nor did we find any history of frequent separations from love objects or evidence of depreciation or rejection. On the other hand, every case of chronic depressive reaction was accompanied by clinically diagnosable depression in at least one parent. Within this category we also found many instances of frequent separations, some evidence of depreciation and rejection, and less frequent occurrences of loss of involvement. In the masked depressive reaction there was often an acute loss or a loss of involvement and almost always depreciation and rejection, but parental depression was found only infrequently.

In summary, our investigation suggests that the sine qua non in acute depressive reactions is the sudden loss of a love object and that the sine qua non in chronic depressive reactions is depression in at least one parent. In masked depressive reactions, however, there does not appear to be a universal factor.

REFERENCES

1. Schildkraut JJ: Biogenic amine metabolism in depressive illness: basic and clinical studies, in Recent Advances in the Psychobiology of Depressive Illness. Edited by Williams TA, Katz MM, Shield JA Jr. Washington, DC, Department of Health, Education, and Welfare, 1972, pp 11–23
2. Shagass C: Electrophysiology of depression, in Pharmacotherapy of Depression. Edited by Cole JO, Whittenborn JR. Springfield, Ill, Charles C Thomas, 1966, pp 91–111
3. Mason JW: A review of psychoendocrine research on the pituitary-adrenal cortical system. Psychosom Med 30:576–607, 1968
4. Sachar EJ: Corticosteroids in depressive illness: a reevaluation of control issues and the literature. Arch Gen Psychiatry 17:544–553, 1967
5. Winokur G, Clayton PJ: Family history studies, I: two types of affective disorders separated according to genetic and clinical factors. Recent Advances in Biological Psychiatry 9:35–50, 1967
6. Winokur G, Clayton PJ, Reich T: Manic-Depressive Illness. St Louis, CV Mosby Co, 1969
7. Annell A: Etiology and background factors, in Depressive States in Childhood and Adolescence. Edited by Annell A. Stockholm, Almquist & Wiksell, 1972, pp 77–151
8. Bowlby J: Maternal Care and Mental Health. New York, Columbia University Press, 1951
9. Bowlby J: Pathological mourning and childhood mourning. J Am Psychoanal Assoc 11:500–541, 1963
10. Freud A: Normality and Pathology in Childhood. New York, International Universities Press, 1965
11. Freud S: Mourning and melancholia, in Collected Papers, vol 4. Edited by Jones E. London, Hogarth Press and Institute of Psychoanalysis, 1950, pp 152–170

12. Mahler MS: Notes on the development of basic moods: the depressive affect, in Psychoanalysis—A General Psychology. Edited by Loewenstein RM, Newman LM, Schurr M, et al. New York, International Universities Press, 1966, pp 152–168
13. Spitz RA: Anaclitic depression. Psychoanal Study Child 2:313–342, 1946
14. Stutte H: Psychosen im Kindesalter und in der Pubertat. Med Klin 58:526–542, 1963
15. Cytryn L, McKnew DH Jr: Proposed classification of childhood depression. Am J Psychiatry 129:149–155, 1972

Truth, Honesty, and the Therapeutic Process

BY LEON SALZMAN, M.D.

The place of honesty and truthfulness in the therapeutic process has rarely been discussed in the psychiatric literature, although Freud placed great emphasis on the need for truthfulness. The author affirms the importance of absolute honesty by both therapist and patient, but cautions that the patient's ability to be honest may be limited by neurotic defenses and that the therapist must use discretion in sharing his honest appraisals with the patient. "Truth" is distinguished from honesty by the author, and its place in therapy is evaluated.

A BASIC PREMISE of a therapeutic relationship and an essential part of the contract the patient makes in establishing it is to be honest and truthful. Although the concepts of honesty and truth are rarely mentioned in the psychiatric or psychoanalytic literature, Freud referred to them constantly. He stated:

> The psychoanalytic treatment is founded on truthfulness. A great part of its educative effect and its ethical value lies in this very fact. . . . Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught by them in a departure from the truth (1).

In order for the therapeutic process to be useful to our patients, they must tell us what concerns them, with a minimum of distortion or withholding, to the extent that their emotional capacity and cognitive integrity permit. What is the therapist's part in this arrangement? How much should he tell or withhold from the patient? To communicate our feelings, attitudes, observations, or interpretations to our patients may be essential to the process of therapy, but at times such communication can be destructive. Is this countertransference or simply an essential part of the therapeutic arrangement?

Dr. Salzman is Deputy Director, Bronx State Hospital, 1500 Waters Pl., Bronx, N.Y. 10461, and Clinical Professor of Psychiatry, Albert Einstein College of Medicine, New York, N.Y.

THE DISTINCTION BETWEEN HONESTY AND TRUTH

First, we must clarify our concepts. Honesty is not the same as truth, although the two are related. Webster defines truth as "the state of being the case: fact," while honesty is defined as "fairness and straightforwardness of conduct or adherence to the facts." I would like to suggest that honesty is a dynamic concept that is based on an individual's sincere and objective attempt to appraise a total situation and that is limited by his inability to be totally unbiased. Truth, on the other hand, is a matter of definition and varies according to the framework in which it is established—whether scientifically, as in natural laws, or morally, as determined by man or God. As Oppenheimer has stated, "Truth is so largely defined by how you find it" (2, p. 101). He meant simply that what is true depends upon how one sets out to determine the truth.

This distinction is crucial in a discussion of the place of truth, honesty, and trust in the therapeutic process. For example, we must recognize that honesty is not exclusively a moral issue, since it is determined by the degree of freedom the person has to explore, express, and determine the truths in his environment. A person's honesty is strongly influenced by the amount of neurotic defenses he has and the degree of distortion he unconsciously imposes on the environment by such behaviors as denial, projection, or dissociation. The degree of honesty a person expresses is determined by the amount of security and self-esteem he has, which allows him to be more or less honest in seeing a situation as it really is. Dishonesty, whether consciously elaborated or unconsciously demonstrated, is a defensive maneuver designed to support a neurotic system. We distinguish between the deliberate and the unconscious liar only because we still tend to assign moral judgments to those types of distortion.

Is the child lying when he tells you about the fire engine drawn by elephants and led by a maharajah, à la Dr. Suess, or is he simply using his imagination? Are our patients being dishonest when they deny that they are ir-

ritated when we cut short their hours—because they are afraid we will get angry and terminate therapy? Is a patient being dishonest when he unconsciously falsifies a childhood experience by remembering it as having been bitten by a dog rather than as having kicked and hurt the dog?

These examples illustrate some of the vagaries of the concept of honesty and demonstrate why it cannot simply be appraised but must be understood in the context of the experience. Honesty is the potential to see a situation for what it is; it is achieved only when one has a minimal need to defend oneself against anxiety because one has sufficient self-regard. Whether we communicate this honest appraisal of a situation in a truthful statement or withhold it for reasons we believe are justified, our goal in the training of therapists should certainly be to encourage and develop basic honesty in our human contacts. Dishonesty is the inevitable consequence of the neurotic structure and occurs when a person's defenses demand some distortion of reality—by total reversal, slight distortion, exaggeration, minimizing, shading, etc. In therapy, this tendency is generally not categorized as dishonesty but rather is considered a problem of defense. The therapist should refrain from moralizing judgments and recognize that these distortions are a necessary activity in the neurotic state.

This link between neurosis and dishonesty has led many theorists, particularly Horney and Sullivan, to consider neuroses immoral and to classify them as "ethical diseases." Certainly the neurotic is dishonest but, since he is unable to make any choices, his dishonesty is imposed upon him by his neurosis. He does not wish it and would like to rid himself of it. The psychotic individual, whether his psychosis is of an organic or psychological origin, likewise describes events and experiences in a manner that deviates widely from fact. These reports are labeled delusions, hallucinations, faulty perceptions, confabulations, and the like. The issue of honesty or truth is not raised in regard to them, although we occasionally designate malingering as a deliberate attempt to deceive or defraud. In therapy we prefer to talk about defenses rather than honesty, since the problem of honesty is very loaded with ethical and theological judgments.

The matter of honesty leads us to an examination of the concept of truth. There are many interesting definitions of truth. All of them are true, yet none of them is entirely true. And this is precisely the limitation of the concept of truth, unless we believe in an absolute truth. To say that something is absolutely true is immediately to tell a lie, for truth is entirely dependent on our frame of reference, as Einstein plainly demonstrated in his experiments in relativity. Yet if we limit our definition of truth to some relativistic or indeterminate sense, we have chaos. Consequently, civilized societies have agreed on some basic truths as a foundation for morality.

HONESTY AND TRUTH IN THERAPY

In the therapeutic process honesty is an essential for patient and therapist. It is unthinkable that a rational, humanistic, nonauthoritarian healing process can take place without it. Yet it is too often demanded of the patient and not often enough required of the therapist. Many therapies, such as magic, proceed in an atmosphere that could be described as dishonest, but these are not subsumed under the strict category of psychotherapy by mutual exchange, as defined by Freud.

What needs to be clarified is not whether one should be honest, but how to use our hónest evaluations in an effective way. This is exclusively a question of technique, or at least it should be. Although we should not knowingly deviate from honest appraisals in our therapeutic work, we must constantly decide how best to utilize these appraisals. The question is not when should we be honest but when should we communicate our honest observations so that they most effectively serve the therapeutic process. In the case of a patient with incipient schizophrenia, there is no question about *whether* we should interpret to him a dream caused by severe anxiety that presages emotional disorganization; it is only a matter of *when* to do it. Likewise, we must decide *when* to inform a patient that we dislike some behavior and find it obnoxious (not should we or should we not).

The therapist's honesty in appraising such situations must be assumed and required without question. *What* we communicate, however, is a different question from whether or not we honestly appraise the total situation. We must not confuse honesty with technique, for without a basic honesty the therapy itself is in jeopardy and the technical problem never arises.

Unfortunately, for many therapists this decision never occurs, for they automatically decide to withhold unpleasant or distressful observations from patients because of their own inability to handle the consequences. In such cases, however, we are not dealing with honesty or truth but with an incompetent or immature therapist who has greater concern for his own welfare than for that of his patient. At times, of course, it may be the overwhelming characterological problems of the patient that put the therapist on the defensive, and one must acknowledge that this can happen to any therapist, however skillful, experienced, or mature.

On the matter of truth I think we can be much clearer. I cannot visualize many situations in which an untruth can be justified in the healing profession. Certainly we can argue endlessly about the dilemma of the patient with incurable cancer, but, aside from this, I think we would all agree that in the psychotherapeutic process an untruth is never justified. This must be clearly distinguished from withholding the truth for definable reasons. Our rationalizations may be incorrect, our justifications fallacious, but withholding the truth is quite different from telling a patient a lie. Freud made this clear in his statement quoted above. Certainly it is easy to justify withholding the truth from patients for reasons ostensibly beneficial to them when we are really protecting ourselves. It is easy to blame failures in therapy on our patients when our own skills are at fault. But this is a matter of recognizing our own deficiencies. In my opinion our patients

are better able to handle unpleasant material than we ever give them credit for.

Yet here again we must not confuse technique with truth. In the present state of development of psychological theory our interpretations and observations are a long way from being verifiable, and consequently we may not be withholding a *truth* if we refrain from making an interpretation, but only an *opinion*. We can establish some honesty in our appraisal only if we allow ourselves the freedom to examine human experience from a standpoint that is not biased or preconceived. The truthfulness of these observations will be determined somewhere far in the future.

At present we work only with skilled guesses, approximations, and rudimentary scientific observations and we must never fool ourselves about this fact. Frequently we present our educated guesses and approximations to our patients as though they were established truths. Such misrepresentations are as harmful as lying or withholding, and perhaps more so, since they occur so frequently. We must avoid the temptation to use our status to establish a set of "truths" that may be far removed from any acceptable definition of truth.

The purpose of distinguishing between honesty and truth in therapy is to stress the wisdom of using certain technical interventions in the therapeutic process. Although there is no virtue in a doctrine of absolute truthfulness in the therapeutic process, there seems never to be a justification for deception. But just as honesty is relative to the patient's sense of security, so must we recognize that the therapist is also human, and therefore subject to neurotic difficulties, defending himself with denials, and seeing less than the whole truth. We hope, however, that he has less need for such defenses than the patient does, and consequently we believe we have a right to expect less deception on his part.

REFERENCES

1. Freud S: Introductory lectures, in Complete Psychological Works, standard ed. Translated and edited by Strachey J. London, Hogarth Press, 1963
2. Oppenheimer JR: The Open Mind. New York, Simon and Schuster, 1955

Once More: The Inaccuracy of Non-EEG Estimations of Sleep

BY BRIAN L. WEISS, M.D., RICHARD J. MCPARTLAND, M.E.E., AND DAVID J. KUPFER, M.D.

To test the validity of nurses' estimates and patients' self-reports of the duration and quality of the patients' sleep, the authors compared these estimates with measures of sleep taken with the electroencephalogram. The authors found that nurses correctly estimated the amount of sleep of only two of the 14 subjects and tended to consistently overestimate. Patients showed no tendency to consistently overestimate or underestimate, but only four of the 14 patients correctly estimated the duration of their sleep. The authors argue that conclusions about sleep patterns that are based on observational methods will have to be reexamined.

SINCE CHANGES in sleep patterns have been observed in the course of many psychiatric disorders, it is now widely held that understanding the nature and extent of these changes will assist in the diagnosis and treatment of mental disorders. All-night electroencephalogram (EEG) sleep studies have already yielded significant information about the sleep patterns of acute schizophrenics, psychotic and nonpsychotic depressives, and psychotic alcoholics (1–5). Although the validity of the EEG in distinguishing sleep from waking states is beyond dispute, EEG sleep equipment is expensive and not widely available, and this prevents its broad use in clinical settings. Instead, observations and estimates by nurses and family members and self-reports by patients have been employed routinely; until recently, many conclusions about sleep patterns in psychiatric disorders have been based primarily on these observational methods (6–10).

At the time this work was done, the authors were with the Department of Psychiatry, Yale University School of Medicine, and the Connecticut Mental Health Center, New Haven, Conn. They are now with the Department of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, Pa. 15261, where Dr. Weiss is Assistant Professor, Mr. McPartland is Research Associate, and Dr. Kupfer is Associate Professor and Director of Research.

This work was supported in part by Public Health Service grant MH-70012 (Research Scientist Development Award to Dr. Kupfer) from the National Institute of Mental Health.

The authors wish to thank the staff of the Research Unit, Connecticut Mental Health Center.

Although one earlier study reported a high degree of agreement between nurses' estimates of sleep duration and measurements taken by the EEG for psychiatric patients with unspecified diagnoses (11), a more extensive study found serious discrepancies between EEG measurements and the systematic observations by nurses of the duration of sleep in depressed patients (12). However, a high positive correlation between EEG measurements and nurses' estimates was noted in the case of patients with acute schizophrenia. The patients' own estimates of their sleep duration were not included in this report, and therefore no comparison with the nurses' estimates or the EEG measurements was obtained.

Since EEG measurements, nurses' estimates of sleep duration, and patients' self-reports on the quality and duration of their sleep were routinely recorded in our clinical research setting, we were able to compare the validity of subjective techniques with the EEG measurements as well as determine whether the patients' reports of sleep quality are correlated with any of the measures of sleep duration.

METHOD

Fourteen hospitalized patients (seven with depressive syndromes and seven with schizophrenia) were studied on the psychiatric research ward of the Connecticut Mental Health Center. Using standardized clinical interviews, the Brief Psychiatric Rating Scale (13), and patient self-rating forms (14), three psychiatrists independently diagnosed each patient. Our studies were not begun until at least two weeks after the patient's admission. The characteristics of the 14 patients are shown in table 1. All-night EEG measurements, nurses' observations, and patients' self-ratings of the duration and quality of sleep were recorded for each of the 14 patients for 14 consecutive nights; 196 seperate records were therefore made.

Continuous EEG, submental electromyogram, and horizontal electrooculogram recordings were made while the patients slept in their own beds on the research ward. These records were evaluated according to standardized techniques (15) by a scorer who was unaware of the patients' or nurses' ratings. At 30-minute intervals, using averted flashlights, nurses who had been trained on the research ward routinely and conscientiously observed whether each patient was asleep or awake. The patients were instructed to raise their hands as the nurses entered their rooms if they were awake. A patient was considered to be asleep if he displayed regular respiration, closed eyes, relaxation and immobility, and relative lack of response to minor environmental stimuli. The nurses then immediately recorded each observation.

All patients were routinely asked after each night of their hospitalization how many hours (to the nearest half hour) they had slept. The question was posed seriously, and only serious replies were tolerated. In addition, each patient was asked to rate the quality of his sleep that night on a scale of 1 to 5 (1 = very poor, 2 = poor, 3 = fair, 4 = good, 5 = very good).

TABLE 1
Characteristics of Patients

Diagnosis	Number	Age Range	Mean Age	Sex	
				Men	Women
Depression	7	25–63	49.7	1	6
Schizophrenia	7	17–27	21.6	4	3

The data that were obtained from the EEG measures, the nurses' estimates of sleep duration, and the patients' estimates of sleep duration and quality were analyzed by use of the Pearson product-moment correlation coefficient and the t test for paired observations. The nurses' and patients' estimates were considered valid if: 1) their correlation with the EEG measures was significant at the .05 level of confidence or better and 2) the two-tailed t test showed no significant differences (i.e., $p > .05$) between the estimates and the EEG measures; these criteria for validity have been used previously (12). The requirement that p be greater than .05 on the t test was designed to eliminate high correlations that are the result of patients' or nurses' consistent overestimation or underestimation of the duration of the patients' sleep.

RESULTS

Our results demonstrated a marked lack of validity in both nurses' and patients' estimates of sleep duration (tables 2 and 3). The nurses were able to make valid estimates for only one depressive and one schizophrenic patient. The patients' self-estimations were only slightly more accurate. Of the 14 patients, one depressive and three schizophrenic patients were able to satisfactorily estimate the number of hours they had slept. The depressive group slept an average of 342 minutes and the schizophrenic group averaged 393 minutes.

In the overall sample, nurses' and patients' estimates did not correlate highly with each other. In each of the two patient groups, only three out of seven patients' estimates reached acceptable levels of correlation with the nurses' estimates.

The data were further analyzed to determine whether any consistent overestimation or underestimation was made by the nurses or patients. It was found that the nurses overestimated the sleep of all seven schizophrenic patients (the average overestimation was 63 minutes per night, $p < .01$) and the sleep of four of the depressed patients. Neither schizophrenic nor depressed patients showed any consistent tendency toward overestimation or underestimation.

Correlations between the patients' ratings of the quality of their sleep and the EEG measures, nurses' estimates, and patients' estimates of the duration of their sleep are shown in table 4. The patients' ratings of sleep quality were correlated significantly with the EEG measures for only two depressed and three schizophrenic

TABLE 2
Validity of Nurses' Estimates on the Basis of Correlations Between EEG Measurements and Nurses' Observations of Sleep Duration

Patient	Correlation Coefficient
Valid estimates*	
D6**	.96***
S10	.74***
Nonvalid estimates	
D1	.82†
D2	.71†
D3	.85†
D4	.80†
D5	.36
D7	.77†
S8	.18
S9	.89†
S11	.49
S12	.57†
S13	.30
S14	.84†

* For an estimate to be considered valid, two conditions must be met: 1) the correlation must be significant at .05 or better, and 2) there must be no significant difference between the nurses' estimate and the EEG measurement, i.e., on the two-tailed t test, p must be greater than .05.
** "D" refers to patients with depression and "S" to those with schizophrenia.
*** Significance of the correlation is $p<.01$.
† Although the correlation was significant at $p<.05$ or better, the estimate was nonvalid because p was less than .05 on the two-tailed t test for paired observations, indicating consistent overestimation or underestimation by the nurses.

TABLE 3
Validity of Patients' Estimates on the Basis of Correlations Between EEG Measurements and Patients' Observations of Sleep Duration

Patient	Correlation Coefficient
Valid estimates*	
D3	.96**
S9	.64
S10	.73**
S11	.60
Nonvalid estimates	
D1	.54***
D2	.63***
D4	.83***
D5	.49
D6	.81***
D7	.70***
S8	−.15
S11	.46
S13	−.15
S14	.82***

* For an estimate to be considered valid, two conditions must be met: 1) the correlation must be significant at .05 or better, and 2) there must be no significant difference between the patient's estimate and the EEG measurement, i.e., on the two-tailed t test, p must be greater than .05.
** Significance of the correlation is $p<.01$.
*** Although the correlation was significant at $p<.05$ or better, the estimate was nonvalid because p was less than .05 on the two-tailed t test for paired observations, indicating consistent overestimation or underestimation by the patients.

patients, with the nurses' estimates for two depressed and three schizophrenic patients, and with the patients' estimates of duration for three depressed and three schizophrenic patients. Only four of the 14 patients' ratings of sleep quality showed significant correlations with all three measures of sleep duration. For more than half the patients, there was no statistically significant correlation between the total amount of sleep as registered on the EEG and the patients' subjective impressions of the quality of their sleep.

DISCUSSION

Our results cast serious doubts once again on the validity of either nurses' or patients' estimations of sleep and on their usefulness in clinical research. Nurses were particularly erroneous, since they accurately gauged the sleep of only two of the 14 patients. The fact that systematic observations of sleep by nurses are not valid for depressed patients has been noted before (12); our replication of this finding is especially noteworthy, because sleep disturbances in depressive syndromes have received widespread attention. Some diagnostic subgroups of depressive illness have been established on the basis of sleep patterns (8, 16–18) and changes in sleep patterns have been used in part to determine the effectiveness of certain treatment methods (19–23). However, conclusions like these, based on the findings of studies that rely solely on nurses' or patients' observations of sleep patterns, may have to be discarded.

With regard to acute schizophrenia, our findings do not support those of a previous study in which nurses' estimates of the sleep of schizophrenics were found to be valid (12). This discrepancy may be attributable to differences in the severity of illness of the patients. The seven

TABLE 4
Correlations Between Patients' Reports of Sleep Quality and Various Measures of Sleep Duration

Patient	Correlation Coefficients		
	EEG Measurement	Nurses' Estimates	Patients' Estimates
D1	−.13	−.04	−.15
D2	−.06	.00	−.16
D3	.63*	.61*	.77**
D4	.68**	.25	.70**
D5	.49	.28	.13
D6	−.31	−.28	−.21
D7	.44	.54*	.55*
S8	−.23	.11	.22
S9	.72**	.76**	.87**
S10	.61*	.65*	.85**
S11	.03	−.08	−.24
S12	.27	.05	.35
S13	−.52	.01	.15
S14	.70**	.75**	.81**

* The correlation is significant at $p<.05$.
** The correlation is significant at $p<.01$.

acutely schizophrenic patients in the previous study were highly agitated and they were in the most intense phase of their illness. Since these patients tended to be quite active when they were not asleep, there was usually a clear distinction between their waking and sleeping states. By contrast, the seven schizophrenics in our study, although they were all actively psychotic, usually remained in their beds at night. This difference is reflected in the fact that the schizophrenics in the earlier study slept an average of only 312 minutes each night, compared with 393 minutes in our study. It is not surprising therefore that the nurses' estimates of sleep for our schizophrenic patients were just as invalid as those for the depressed group. In addition, the nurses' ratings were characterized by consistent overestimation for all seven schizophrenics.

Furthermore, the patients' estimations of their sleep duration were also invalid: only one depressed patient and three of the seven schizophrenics could accurately assess their total sleep time. The not uncommon clinical situation in which the nurse and the patient disagree over how many hours of sleep the patient has had that night is easily understood in the light of these findings. No significant trends toward overestimation or underestimation could be discerned in the patients' self-ratings.

The lack of correlation between the patients' ratings of the quality of sleep and the various measures of sleep duration suggests that factors other than the amount of sleep a patient gets are involved in the subjective assessment of sleep quality. These factors may include the amount of time spent in the various sleep stages, such as stage 4 or stage REM; incidents of sleep disruption, such as intermittent nocturnal awakening; or changes in other characteristics of sleep, such as sleep latency. When "poor" sleepers were compared with "good" sleepers, a higher level of physiological functioning, especially an increase in body movements, was reported (24, 25). High positive correlations between the number of body movements during sleep and levels of nighttime telemetric activity have also been reported (26) and nighttime activity levels have also been significantly correlated with other measures of sleep disruption, such as reduction in the total time spent sleeping and an increase in sleep latency, intermittent awakening, and early morning awakening (5, 26, 27). It may be that sleep quality is inversely related to the level of psychomotor activity. Therefore, hypnotic drugs that merely increase the duration of sleep without affecting levels of psychomotor activity may not be effective in improving the quality of sleep. We are currently investigating these possibilities in our attempts to use objective indices of sleep in our research.

REFERENCES

1. Gross MM, Goodenough D, Tobin M, et al: Sleep disturbance and hallucinations in the acute alcoholic psychoses. J Nerv Ment Dis 142:493–514, 1966
2. Hawkins DR, Mendels J, Scott J, et al: The psychophysiology of sleep in psychotic depression: a longitudinal study. Psychosom Med 39:329–343, 1967
3. Kupfer DJ, Wyatt RJ, Scott J, et al: Sleep disturbance in acute schizophrenic patients. Am J Psychiatry 126:1213–1220, 1970
4. Snyder F: Dynamic aspects of sleep disturbance in relation to mental illness. Biol Psychiatry 1:119–130, 1969
5. Kupfer DJ, Foster FG: Sleep and activity in a psychotic depression. J Nerv Ment Dis 156:341–348, 1973
6. Hinton JM: Patterns of insomnia in depressive states. J Neurol Neurosurg Psychiatry 26:184–189, 1963
7. Samuel JG: Sleep disturbance in depressed patients: objective and subjective measures. Br J Psychiatry 110:711–719, 1964
8. Costello CG, Selby MM: The relationship between sleep patterns and reactive and endogenous depressions. Br J Psychiatry 111:497–501, 1965
9. Grumet G: Severe insomnia in psychiatric inpatients. Dis Nerv Syst 29:256–258, 1968
10. Kupfer DJ, Harrow M, Detre TP: Sleep patterns and psychopathology. Acta Psychiatr Scand 45:75–89, 1969
11. Erwin CW, Zung WWK: Behavioral and EEG criteria of sleep in humans. Arch Gen Psychiatry 23:375–377, 1970
12. Kupfer DJ, Wyatt RJ, Snyder F: Comparison between electroencephalographic and systematic nursing observations of sleep in psychiatric patients. J Nerv Ment Dis 151:361–368, 1970
13. Overall JE, Gorham DR: The Brief Psychiatric Rating Scale. Psychol Rep 10:799–812, 1962
14. Kupfer DJ, Detre TP: Development and application of the KDS-1 in inpatient and outpatient settings. Psychol Rep 29:607–617, 1971
15. Rechtschaffen A, Kales AA: A Manual of Standardized Terminology, Techniques, and Scoring System for Sleep Stages of Human Subjects. Bethesda, Md, National Institute for Nervous Diseases and Blindness, 1968
16. Widmann DE, Prange AJ, Cochrane CC: Sleep as a sign and as a symptom in depressive illness. Dis Nerv Syst 28:314–317, 1967
17. Detre TP, Himmelhoch J, Swartzburg M, et al: Hypersomnia and manic-depressive disease. Am J Psychiatry 128:1303–1305, 1972
18. Kupfer DJ, Himmelhoch J, Swartzburg M, et al: Hypersomnia in manic-depressive disease. Dis Nerv Syst 33:720–724, 1972
19. Oswald I, Berger RJ, Jaramillo RA, et al: Melancholia and barbiturates: a controlled EEG body and eye movement study of sleep. Br J Psychiatry 109:66–78, 1963
20. Exton-Smith AN, Hodkinson HM, Cromie BW, et al: Controlled comparison of four sedative drugs in elderly patients. Br Med J 2:1037–1040, 1963
21. Loprete FP, Palm C: Sleep in psychotic patients: a comparative clinical study. Int J Neuropsychiatry 3:497–500, 1967
22. Hartmann E: The effects of four drugs on sleep patterns in man. Psychopharmacologia 12:346–353, 1968
23. Himmelhoch JM, Detre TP, Kupfer DJ, et al: Treatment of previously intractable depressions with tranlcypromine and lithium. J Nerv Ment Dis 155:216–220, 1972
24. Monroe LJ: Psychological and physiological differences between good and poor sleepers. J Abnorm Psychol 72:255–264, 1967
25. Rechtschaffen A: Polygraphic aspects of insomnia, in The Abnormalities of Sleep in Man: Proceedings of the 15th European Meeting on Electroencephalography. Edited by Gastaut H. Bologna, Gaggi, 1968, pp 109–125
26. Kupfer DJ, Detre TP, Foster FG, et al: The application of Delgado's telemetric mobility recorder for human studies. Behavorial Biology 7:585–590, 1972
27. Weiss BL, Kupfer DJ, Foster FG, et al: Activity, sleep, and biogenic amine metabolites in depression. Life Sci (submitted for publication)

Imipramine Withdrawal: An Akathisia-Like Syndrome

BY GREGORY L. SATHANANTHAN, M.D., D.P.M., AND SAMUEL GERSHON, M.D., D.P.M.

The authors report on three patients who developed an akathisia-like syndrome after the abrupt withdrawal of imipramine. They discuss a possible link between this phenomenon and dopamine turnover in the central nervous system.

WITHDRAWAL SYMPTOMS after cessation of neuroleptic drugs have been reported in the literature (1, 2), but none of the reports has linked the withdrawal symptoms to any biochemical phenomenon. This paper describes three patients who developed withdrawal symptoms after abrupt discontinuance of imipramine. A possible biochemical basis for this phenomenon is offered.

CASE REPORTS

Case 1. This patient, a 42-year-old white man, was admitted to Bellevue Psychiatric Hospital with a diagnosis of psychotic depression. On examination he was found to be severely depressed, had clear-cut suicidal ideation, and felt hopeless, helpless, and worthless. Motor retardation, insomnia, and loss of weight were also associated with his illness. He had had two previous episodes of such symptoms; this episode had begun two weeks earlier. He was started on 75 mg. of imipramine (Tofranil) a day in three divided doses; this was increased to 450 mg. daily, also in three divided doses. At the end of three weeks on the medication the patient's condition had not improved. In fact, his clinical status showed a mild deterioration. At this time the imipramine was discontinued, and no other medication was substituted. About 24 hours after discontinuance of the imipramine he developed acute anxiety and restlessness. He could not stay still but paced up and down the ward. His behavior was observed for about two hours, then he was given 75 mg. of imipramine by mouth. His symptoms abated within an hour and a half. The dosage was decreased from 75 mg. three times a day to zero over three days without a recurrence of the symptoms.

Case 2. This 55-year-old white man was admitted to Bellevue with a diagnosis of manic-depressive illness, depressive phase. He had been ill for about two weeks. At the time of admission, he was found to be severely depressed, with feelings of hopelessness and worthlessness. The reason for the admission was a suicide attempt—he had tried to cut his wrists. He was placed on imipramine in increasingly larger doses; at the end of the three weeks, he was receiving 375 mg. a day in three divided doses. In spite of this treatment he showed a steady deterioration. At this point the imipramine was discontinued, and he was given no other medication. About 24 hours later he developed acute anxiety and motor restlessness; he too paced up and down the ward. Within two hours after the oral administration of 100 mg. of imipramine the symptoms disappeared. The imipramine was gradually discontinued over a period of three days, with no recurrence of the symptoms.

Case 3. A 40-year-old black woman was admitted to Bellevue with a history of psychotic depression. This was her first psychiatric admission. She was depressed and expressed feelings of hopelessness and worthlessness and also exhibited motor retardation, insomnia, and loss of weight. She was placed on increasing doses of imipramine until she reached a maximum dose of 300 mg. a day, given in three divided doses. Her symptoms cleared after about two weeks. At the end of four weeks in the hospital she was discharged with instructions to take 300 mg. of imipramine a day in three divided doses, but she failed to have her prescription filled. She came back to the ward the next day (about 24 hours after her last dose of imipramine) in a state of acute anxiety and motor restlessness. A dose of 100 mg. of imipramine was given orally, and her symptoms subsided within two hours. Once home, she continued to take her imipramine and the symptoms did not recur.

DISCUSSION

Withdrawal reactions to imipramine have been reported a number of times. Kramer and associates (3) studied 45 patients and reported that 25 of them developed withdrawal reactions, which consisted of nausea, headache, dizziness, and muscular pain. Mann and MacPherson (4) described two cases of nausea, vomiting, dizziness, and anxiety after cessation of imipramine. Anderson and Kristiansen (5) reported similar withdrawal symptoms in 15 of their 85 cases.

The three patients reported by us developed acute anxiety, motor restlessness, and inability to sit still. The clinical picture was indistinguishable from akathisia—a state that might be caused by depletion of or hypersensitivity to dopamine in the central nervous system (6). The fact that this akathisia-like syndrome appeared after imipramine had been abruptly withdrawn and disappeared when the imipramine was again started establishes that this syndrome is specifically related to the withdrawal of the drug. Further, this type of reaction appears in both responders and nonresponders to imipramine; of the three patients reported here, two were nonresponders and one was a responder.

Drs. Sathananthan and Gershon are with the Neuropsychopharmacology Research Unit, Department of Psychiatry, New York University Medical Center, 550 First Ave., New York, N.Y. 10016, where Dr. Sathananthan is Clinical Instructor of Psychiatry and Dr. Gershon is Professor of Psychiatry.

The authors thank Dr. E. Friedman for his advice during the preparation of this paper.

Since akathisia and certain hyperactive states are related to central dopamine mechanisms, we considered the possibility that this withdrawal phenomenon might also be mediated through a similar mechanism. Schildkraut (7) postulated that the clinical action of imipramine is due to its ability to prevent the reuptake of norepinephrine into the neurons, thus making more norepinephrine available at the receptor site. Carlsson and associates (8) postulated that the action of imipramine is similar to, but mediated through, serotonin. Whether dopamine is implicated in the action of imipramine is unclear; evidence in the literature is sparse. Glowinsky and associates (9) reported that, in rat brain, desmethylimipramine—a metabolite of imipramine—caused a slight increase in the H^3-dopamine levels. Friedman and Gershon (10) stated that tricyclic antidepressants do not inhibit the uptake of dopamine into aminergic neurons in the brain. In both these reports, imipramine was given in an acute loading dose. Data on chronic administration of imipramine leave the question of depletion of dopamine in the central nervous system unanswered (11).

There is evidence that drugs with known antidopamine activity alter hyperkinetic symptoms (12). In view of this, we postulate that the akathisia-like syndrome seen in our three patients might have been due to sudden functional depletion of dopamine at the receptor site. Over the three-week period of imipramine treatment in these patients, there was an accumulation of dopamine in the receptor site, by mechanisms similar to those postulated for norepinephrine and serotonin. The abrupt withdrawal of imipramine caused a sudden decrease in dopamine at the receptor site. This, together with the fact that imipramine does not significantly increase the synthesis of dopamine in the brain, caused a functional decrease in the available dopamine in the central nervous system. This functional depletion of dopamine or the hypersensitivity of the neurons to newly synthesized dopamine might have caused the akathisia-like syndrome. This hypothesis fits in with the probable explanation for the occurrence of this syndrome in parkinsonian patients (13).

Another explanation of the withdrawal symptoms was offered by Shatan (14). He suggested that the symptoms are due to the fact that imipramine may have the properties of a potentially addictive drug—that it causes a withdrawal phenomenon—and that this withdrawal can be corrected by the reintroduction of the drug. Whatever the explanation, this syndrome appears to have a biochemical basis since it occurs in both responders and nonresponders to the drug, in both unipolar and bipolar depressives, and in both sexes, and the symptoms disappear when the drug is reinstituted.

REFERENCES

1. Brooks GW: Withdrawal from neuroleptic drugs. Am J Psychiatry 115:931–932, 1959
2. Gallant DM, Edwards CG, Bishop MP, et al: Withdrawal symptoms after abrupt cessation of antipsychotic compounds: clinical confirmation in chronic schizophrenics. Am J Psychiatry 121:491–493, 1964
3. Kramer JC, Klein DF, Fink M: Withdrawal symptoms following discontinuation of imipramine therapy. Am J Psychiatry 118:549–550, 1961
4. Mann A, MacPherson A: Clinical experience with imipramine (G 22355) in the treatment of depression. Can Psychiatr Assoc J 4:38–47, 1959
5. Anderson H, Kristiansen ES: Tofranil treatment of endogenous depression. Acta Psychiatr Neurol Scand 34:387–397, 1959
6. Medical Research Council Brain Metabolism Unit: The modified amine hypothesis for the aetiology of affective illness. Lancet 2:523–577, 1972
7. Schildkraut JJ: The catecholamine hypothesis of affective disorders: a review of supporting evidence. Am J Psychiatry 122:509–522, 1965
8. Carlsson A, Carrodi H, Fuxe K, et al: Effect of anti-depressant drugs on the depletion of intraneuronal brain 5HT stores caused by 4-methyl-α ethyl meta tyromine. Eur J Pharmacol 5:357–360, 1969
9. Glowinsky J, Axelrod J, Iverson LL: Regional studies of catecholamines in rat brain, IV. J Pharmacol Exp Ther 153:30–41, 1966
10. Friedman E, Gershon S: L-dopa and imipramine: biochemical and behavioural interactions. Eur J Pharmacol 18:183–188, 1973
11. Alpers HS, Himwich HE: Effects of chronic imipramine administration on rat brain serotonin, 5HIAA, NE and dopamine. J Pharmacol Exp Ther 180:531–538, 1972
12. Fog R, Pakkenberg H: Combined nitopran-pimozide treatment of Huntington's chorea and other hyperkinetic syndromes. Acta Neurol Scand 46:249–251, 1970
13. Klawans HL, Rubovitz R, Ringel SP, et al: Observations on the use of methysergide in Huntington's chorea. Neurology (Minneap) 22:929–933, 1972
14. Shatan C: Withdrawal symptoms after abrupt termination of imipramine. Can Psychiatr Assoc J 11 (Suppl):150–158, 1966

Incompetency To Stand Trial: Is Psychiatry Necessary?

BY RICHARD H. BENDT, M.D., EUGENE J. BALCANOFF, M.D., AND GREGORY S. TRAGELLIS, M.S., J.D.

Although psychiatrists disagree about whether they should have a role in the courtroom, the legal system continues to ask their help in evaluating defendants' competency to stand trial. The authors present four case reports that illustrate how psychiatrists can and should participate in the legal process. They also suggest that psychiatrists may be able to help protect a defendant's right to a speedy trial by preventing unnecessary hospitalization.

THE NEED for collaboration between the courts and psychiatrists is made apparent by the continued practice of hospitalizing defendants for the purpose of determining their competency to stand trial, especially when these hospitalizations take place under a criminal commitment. It has been demonstrated that criminal commitment is antitherapeutic in comparison with civil commitment (1). The degree to which the problem still exists is reflected by statistics from the Division of Legal Medicine for the Commonwealth of Massachusetts. From July 1, 1971, to June 30, 1972, there were 1,888 observational commitments to state hospitals in Massachusetts for determinations of competency; 501 of these took place at the maximum security facility at Bridgewater State Hospital. Only 76 of the total 1,888 were actually determined to be incompetent.

Despite the fact that psychiatrists are increasingly called upon to perform pretrial examinations of alleged offenders, there is marked disagreement among psychiatrists about their role in such examinations. In *The Crime of Punishment* (2), Karl Menninger maintained that the psychiatrist should be "excluded from the courtroom" because he is called upon to answer "highly technical questions." John M. Suarez, who has done extensive work in the field of legal psychiatry, has stated that the psychiatrist should have no role in handling an alleged offender until he has been found guilty (3, 4). Suarez' major feeling is that psychiatrists should attempt to change legislation, not involve themselves in pretrial issues. In *Psychiatric Justice*, Szasz asserted that the psychiatrist functions as an agent of the state in trial matters (5). On the other hand, in *The Role of Psychiatry in Law*, Manfred Guttmacher wrote that the psychiatrist should give clinical information relevant to a defendant's capacity to respond to the legal process (6). It was his opinion that the ultimate decision regarding the defendant's competency to stand trial is judicial and that the jury must make the final determination of criminal responsibility. In our court clinic practice, we support his point of view.

We work in the Psychiatric Court Clinic, which is part of the Criminal Division of the Suffolk Superior Court. The two psychiatrists assigned to this clinic (R.H.B. and E.J.B.) have had considerable training and experience in forensic psychiatry. We have also served on a five-year interdisciplinary research project engaged in the examination of the issue of competency to stand trial in Massachusetts.[1] The third member of the staff (G.S.T.) is a lawyer and a psychiatric social worker, a combination that provides a unique advantage in evaluating the defendants and using psychiatric information in the legal process. He is especially helpful in preventing prejudicial errors, particularly in pretrial issues.

This court clinic, established in 1954, is one of 24 such clinics throughout Massachusetts, but it is the only one that functions specifically at the superior court level. Although it has a role in the treatment of offenders, its special function is that of amicus curiae (7), assisting the court both before and during the trial in cases that involve serious and complex psychiatric issues. To facilitate our work, we developed a protocol for the psychiatric referral of alleged offenders by the courts (8). Since the protocol has been in use as a routine referral procedure, it has clarified the issues raised by the court and thereby improved communication among all the people involved in the court's activity. It has also assisted in protecting the defendant from unnecessary hospitalizations.

When the question of a defendant's competency to stand trial is raised by the judge, district attorney, or defense attorney, and if a psychiatrist is not available, the defendant is committed to a state hospital for a period of observation (under Chapter 123 of the general laws of Massachusetts, the period of observation would last at least 20 days). When all studies are completed, the court is notified to transfer the defendant back to the county jail. The defendant must then wait there until his case can be scheduled for a hearing on the issue of his competency. If he is found competent, a trial date will then be set. Because of these transfers and delays in scheduling, the de-

The authors are with the Suffolk Superior Court Clinic, Boston, Mass., where Dr. Bendt is Staff Psychiatrist, Dr. Balcanoff is Director, and Mr. Tragellis is Psychiatric Social Worker. In addition, Dr. Bendt is Instructor in Psychiatry, Harvard Medical School, and Assistant Psychiatrist, McLean Hospital, Belmont, Mass. 02178; and Dr. Balcanoff is Instructor of Clinical Psychiatry, Harvard Medical School, and Lecturer in Psychiatry, Boston College School of Law.

[1]The project, "Competency To Stand Trial and Mental Illness," was supported by Public Health Service grant MH-18112 from the Center for Studies of Crime and Delinquency, National Institute of Mental Health.

fendant may languish in jail for a period of one to three months, and sometimes even longer. An additional problem is that as the defendant is transferred from the hospital to the jail, whatever treatment may have been prescribed for him is often terminated abruptly. Consequently, the defendant may become incompetent once again, a development that will further delay his coming to trial.

CASE REPORTS

Case 1. P.F., a 20-year-old, unmarried man, was brought before the court on a charge of assault and battery with a dangerous weapon. At his first court appearance, he was overtly disorganized and behaved inappropriately. The judge raised the possibility of hospitalization and requested consultation with the court psychiatrist. When the defendant was interviewed about the alleged crime, he told the psychiatrist that an X ray of his skull would reveal "a lot of debris" in his head. He felt that the wax in his ear was part of this debris and that his teeth were also somehow influenced. Although he was oriented as to time, place, and person, his preoccupation with his delusions prevented him from focusing on the reason for his being before the court. Medication was prescribed: 100 mg. of thioridazine (Mellaril) twice a day and 2 mg. a day of trihexyphenidyl (Artane). Within a week he was reexamined and, although some psychotic delusional material was elicited during his mental status examination, his reality was sufficiently restored that he could describe the events surrounding the alleged offense. Medication and supportive therapy during the time he was in custody were essential to his becoming competent to stand trial. He was thus enabled to assist his attorney in preparing his defense. The further delay that would have resulted had he been hospitalized was thereby avoided.

Case 2. F.C., a 22-year-old black man, was brought to court on several charges of rape and assault with intent to rape. During his initial competency hearing, he became extremely anxious and suspicious. He viewed the judge as "grouchy" and felt that he was unable to have a fair trial. His attorney believed that the defendant could not adequately work with him in developing a defense and moved that he be readmitted to the hospital at which he had been observed. In the course of the hearing, his suspiciousness increased and he physically assaulted six court officers. He was seen both immediately and during the following day for a total of two hours of supportive psychotherapy. The psychiatrist tried to explain to the defendant his situation and helped him identify the anxieties and distortions that had limited his ability to cope in the courtroom. Following these interviews, he became less disturbed and was able to work with his attorney to reach the decision that it was in his best interest to enter a plea of guilty in the face of overwhelming evidence. This psychiatric intervention prevented hospitalization.

Case 3. M.C., a 24-year-old white man, was brought before the court on charges of breaking and entering. Because of his arrest, he had to stop his use of oral and intravenous barbiturates abruptly. When he appeared in court the next day for his arraignment, he had an outburst of violent behavior, during which he assaulted his mother and several court officers. The judge questioned the defendant's competency to stand trial but was reluctant to commit him for hospitalization.

The first psychiatric interview took place within an hour of the outburst. At that time, the defendant had little or no memory of the attack and was terrified about what had occurred. The psychiatrist formed the clinical impression that an epileptic seizure had occurred as a result of the defendant's withdrawal from barbiturates. For these reasons, he was given anti-epileptic medication. A second interview, conducted the next day, helped him understand what had occurred. He was then able to return to the arraignment proceedings and go forward with his trial.

Case 4. J.F., a 40-year-old black man, was charged with murder in the first degree. After his attorney and the prosecutor reviewed the evidence, it was agreed that the district attorney would accept a plea of guilty to a lesser charge, manslaughter. The defendant agreed that his attorney should adopt that strategy. At the time of his hearing, however, the defendant became acutely disorganized and suspicious as a result of hearing evidence about the brutality of the crime. At this point, he refused to go forward with the guilty plea. He insisted on a jury trial with a charge of first-degree murder, although there was strong evidence against him. The hearing was discontinued and the judge requested a conference with the court psychiatrist. He was concerned about the defendant's competency to stand trial and wondered whether he should be hospitalized. As an alternative to this, the court psychiatrist saw the defendant in two consultation sessions. By the end of the second session, the patient had apparently managed to alleviate enough of his guilt and anxiety that he was able to review realistically the merits of his attorney's original strategy and to recognize the self-destructive aspects of having pressed for a full jury trial.

CONCLUSIONS

We have described some of the appropriate uses of psychiatric expertise in pretrial evaluation and have emphasized that an outpatient service can both evaluate and treat defendants with psychiatric impairments that make them incompetent to stand trial. By so doing, psychiatrists support the patient-defendant's mental health and protect his legal right to a speedy trial.

REFERENCES

1. McGarry AL, Bendt RH: Criminal versus civil commitment of psychotic offenders: a seven-year follow-up. Am J Psychiatry 125:1387–1394, 1969
2. Menninger K: The Crime of Punishment. New York, Viking Press, 1968
3. Suarez J: The scope of legal psychiatry. Newsletter of the American Academy of Psychiatry and the Law 3:1–2, 1972
4. Suarez J: Psychiatry and the criminal law system. Am J Psychiatry 129:293–297, 1972
5. Szasz TS: Psychiatric Justice. New York, Macmillan Co, 1971
6. Guttmacher MS: The Role of Psychiatry in Law. Springfield, Ill, Charles C Thomas, 1968
7. Balcanoff EJ, McGarry AL: Amicus curiae: the role of the psychiatrist in pretrial examinations. Am J Psychiatry 126:342–347, 1969
8. Bendt RH, Balcanoff EJ, Tragellis G: Psychiatric examination of alleged offenders: a proposed protocol. Journal of the American Bar Association 58:371–373, 1972

Teaching Psychiatry in the Context of Dying and Death

BY DAVID BARTON, M.D.

Instruction in dying and death can be profitably included in the psychiatry curriculum. Through the use of this subject as a teaching focus, improved methods of psychosocial care are fostered and psychiatric principles and phenomena involving the patient and his interpersonal and sociocultural environment emerge in sharp relief. Also, students learn that the problems of dying and death are part of the problems of living.

IN RECENT YEARS, the psychosocial events related to life-threatening illness, dying, and death have received increased interest and attention. Advanced technical skills, the ability to prolong biological life, and the growing numbers of patients in terminal phases of illness who are treated in institutional settings have provided significant impetus in this direction. While in the past these areas have been dealt with largely in biological terms, increasing proximity to the dying patient and the need for more humanistic approaches to the care of these patients necessitate the development of skills to aid in the therapeutic management of the wide spectrum of psychosocial problems related to death and dying.

There is thus a growing need for instruction in this area for medical care-giving personnel. Instruction related to life-threatening illness, dying, and death can profitably be included in the medical school curriculum in personality development courses, general psychiatry courses, and clinical settings (1). An elective course for medical students, designed specifically to teach about the topic, has been developed at Vanderbilt University School of Medicine and is described in some detail in another article (2). In this course patient presentations, presentations by nonphysician health care personnel, and selections from the literature are used to provide focal points for extensive small group discussion. This format has proven to be a satisfactory method of highlighting a number of important and relevant issues, and it provides a setting in which students may begin to work through and synthesize their own attitudes toward and responses to death-related topics and begin to formulate their approaches to the management of the dying patient.

The topic should be recognized as one that is important to the teaching of psychiatry in medical education, for in the course of such instruction the student learns vital concepts related to the psychosocial aspects of medical and surgical practice and gains understanding about a number of basic psychiatric principles. While many of the principles and phenomena related to dying and the threat of death are common to other stages of development and life crises, in the context of life-threatening illness, dying, and death they achieve a level of visibility that facilitates their appreciation and reinforces learning.

Dr. Barton is Associate Professor of Psychiatry, Vanderbilt University School of Medicine, Nashville, Tenn. 37232.

RESPONSES OF THE INDIVIDUAL

Patients demonstrate clearly observable psychological phenomena in response to the crises of life-threatening illness and the events of dying. Basic phenomena such as symbolism are illustrated, and students can readily come to understand how a person might invest the events of illness and the accompanying body image changes, dying, and the threat of death with complex symbolic designations such as weakness, loss of control, or disintegration.

Individual psychodynamic patterns are brought into bold relief. For example, the person may perceive his illness as punishment for real or imagined guilt. There may be intense responses resulting from the person's shift from a position of independence to one of dependency. The person may sense a loss of control and enter into varying forms of behavior in an attempt to restore a sense of mastery. Ego defense mechanisms such as denial, reaction formation, intellectualization, and regression are clearly evident. As in other phases of development, individual adaptation or maladaptation takes varying forms depending on the person's life history and current circumstances. In recognizing this, students come to view dying as being as much a part of the life cycle as other stages, thereby expanding their understanding of human psychological development.

THE INTERPERSONAL DIMENSION

Dying and death are phenomena in which those persons relating to the patient are often dramatically affected by his illness and the patient's responses to it. In the family setting there frequently are marked shifts in attitudes and roles that illustrate a wide spectrum of family psychodynamics. Grief reactions and the process of mourning become apparent and are recognized as an inherent part of the human psychological response to loss.

It is possible that no other life circumstance provides as clear a setting for the student to recognize and begin to understand his own attitudes toward his patients and his expectations of his role as a physician. The bold and defi-

nite quality of the feelings evoked by a patient with life-threatening illness or by one who is dying facilitates the development of this awareness, and the student often experiences and is able to identify these feelings more distinctly than he can with other patients. The student may learn, for example, that his expectations of himself as a physician are set unrealistically high and that such attitudes may cause him to react to some patients with avoidance or overprotectiveness. Through his appreciation of these feelings, some of which may contribute to nontherapeutic responses to his patients, the student is helped to achieve a level of insight that allows him to incorporate self-awareness in the care-giving process. He thus learns that the attitudes and responses of care-giving personnel may serve to aid or impede a person's adaptation to his illness—a vital insight into the nature of the doctor-patient relationship.

Observation of the interaction within the care-giving milieu in response to dying and the threat of death provides the student with an appreciation of the sometimes subtle interchanges among personnel that occur in the provision of care for these patients. The importance of collaborative and cooperative efforts with other care-giving personnel such as nurses, clergymen, and pastoral counselors is emphasized, and the recognition that different persons bring varied expertise, skills, and attitudes into the care-giving process emphasizes the value of a multidisciplinary approach.

THE SOCIOCULTURAL DIMENSION

The wide variety of sociocultural issues related to dying and death may serve to direct the student's attention to the role of social institutions and cultural patterns in the provision of patient care. The student's frame of reference is substantially broadened as he learns that concepts from sociology, philosophy, anthropology, and theology may become significant in the provision of therapeutic care for the dying patient.

ETHICAL CONSIDERATIONS

Although ethics often becomes a salient issue in medical care, students are often excluded from the consideration of decisions involving ethical matters. Yet with increasing medical progress the ethical dilemmas involved in the care of a patient at times become primary considerations in that care. In the context of life-threatening illness, dying, and death, the student is provided with numerous situations that enable him to view the considerations of others and begin to formulate his own approach.

COMMENT

Life circumstances related to dying and death can provide an invaluable teaching setting and a set of situations in which students may learn basic psychiatric principles. Instruction in the topic can be profitably included in the psychiatry curriculum. Through the use of this subject as a teaching focus, improved methods of psychosocial care are fostered, and psychiatric principles and phenomena involving the person and his interpersonal and sociocultural environment emerge in sharp relief. Also, students learn that the problems of dying and death are part of the problems of living.

REFERENCES

1. Barton D: The need for including instruction on death and dying in the medical curriculum. J Med Educ 47:169–175, 1972
2. Barton D, Flexner JM, Van Eys J, et al: Death and dying: a course for medical students. J Med Educ 47:945–951, 1972

Ludwig von Bertalanffy
1901-1972

AS WE VALUE OURSELVES in our profession, so also we value those who have contributed to it. When their contributions are particularly important we signify this by electing them to Honorary Fellowship. On May 8, 1967, the American Psychiatric Association elected Ludwig von Bertalanffy an Honorary Fellow. Now, with a feeling of great loss, we must mark his death: on June 12, 1972, he died suddenly of a heart attack. A simple but beautiful memorial service was held in Williamsville, N.Y., where he lived while occupying the post of University Professor at the State University of New York at Buffalo. He would have thoroughly enjoyed being there, for besides the public figure there was also a very private Ludwig von Bertalanffy who delighted in closeness, intimacy, and friendship. He would have been pleased that there was much talk about his general systems theory and of new applications in the wind that offer hope for the solution of serious problems.

He is survived by his wife and co-worker of 47 years, Maria, a son and co-worker, Felix (a professor of anatomy at the University of Manitoba), his daughter-in-law, Giselle, a host of personal friends, and many others who have been inspired by and benefited from his works.

Ludwig and Maria von Bertalanffy had an almost ideal marriage. They met in a small bahnhof in the Tyrolean Alps, and from then on their life was one of great adventure—geographical, cultural, and, above all, intellectual. Within four years came the publication of *Modern Theories of Development*, which made him an international figure. But this only increased their sense of adventure. He remained always a man who could surmount difficulty, and there were many in his life, the most serious of which was his inability to gain an extension on his stay in this country as a Rockefeller Fellow, with the result that he had to return to Vienna in October 1938. Thus the Von Bertalanffys had to suffer through World War II in a country that had adopted an ideology completely inimical to everything they stood for.

His great conceptions of general systems theory, open systems theory, the *fliessgleichgewicht*—stodgily translated into English as "steady state" but more accurately as "a flowing or streaming equilibrium" (the primary spontaneous activity of the psychophysical organism)—and his concepts of humanism inspired many psychiatrists to alter their course in the pursuit of understanding the functions of the mind. A highlight was reached at the 1965, 1966, and 1967 annual meetings of the American Psychiatric Association, in which sessions on general systems theory and psychiatry were held. Von Bertalanffy's influence has continued to grow since his death, and at the present his works are required reading in an increasing number of psychiatric programs.

His major works included: *Kritische Theorie der Formbildung* (Berlin, 1928), translated into English as *Modern Theories of Development* (Oxford, 1933); *Theoretical Biology*, volumes I and II (Berlin, 1932, 1942); *Problems of Life* (New York, 1952); *Robots, Men and Minds* (New York, 1967); and *General Systems Theory* (New York, 1968).

Ludwig von Bertalanffy was one of the great changers of our time. With his fire and brilliance, his stubbornness and anger, his keen insight and his unwillingness to accept moral neutrality, he succeeded in revising our paradigms about the way the world and our minds work; he also succeeded in his great dream of bringing about unity through diversity. His 270 publications and 13 books, translated into eight languages, are the rich store he leaves for us.

WILLIAM GRAY, M.D.

LETTERS TO THE EDITOR

Drug Dosage in ECT

SIR: I would like to comment on and make some corrections in Dr. Corbett H. Thigpen's Letter to the Editor "Succinylcholine in EST" (June 1973 issue).

While the letter was primarily concerned with the use of pentylenetetrazol (Metrazol) in electroconvulsive therapy, the recommendation to use intravenous diazepam (Valium) as a quieting agent for postictal agitation bears repeating. This recommendation of Dr. Thigpen's provides a significant contribution, even as 20 years ago he and his colleagues made a significant contribution regarding the use of succinylcholine (1).

There are two corrections I must make. First, sodium methohexital (Brevital) should be used in a one-percent solution and dare not be used in a ten-percent solution, as was suggested by Dr. Thigpen. The amount of the dosage can range from 1.5 to 8 cc. Ten to 30 mg. of succinylcholine is sufficient to soften the convulsive reaction; more than this potentiates the hazards of postictal apnea, depending on subsequent experience with the patient. Second, the last sentence in the fourth paragraph should obviously read: "By using pentylenetetrazol [not succinylcholine] the seizure is little more pronounced than in an ordinary successfully administered electroshock treatment."

My thanks again to Dr. Thigpen.

REFERENCE

1. Moss BF Jr, Thigpen CH, Robison WP: Report on the use of succinyl choline dichloride (a curare-like drug) in electroconvulsive therapy. Am J Psychiatry 109:895–898, 1953

MELVIN SIMONSON, M.D.
North Miami, Fla.

SIR: In response to Dr. Thigpen's Letter to the Editor I would like to present some added information on the technique of administering ECT.

In a letter to the *Journal of the American Medical Association* (1) I discussed the use of intravenously administered diazepam as a premedicating and amnesic agent for electoconvulsive treatment. It is my conviction that in replacing the traditional sodium methohexital with the intravenous diazepam the psychiatrist avoids much of the respiratory depression and postictal agitation associated with sodium methohexital and ECT.

However, the daily use of an antecubital vein leads to a palpable venous induration with tenderness within three or four days. One must then use another vein. In my use of diazepam, I never dilute it but perform a pseudo-flushing with succinylcholine as part of the premedication for ECT.

I have had several inquiries regarding my technique of using diazepam in place of sodium methohexital in ECT administration and would be glad to share it with anyone else who might be interested.

REFERENCE

1. Wehlage DF: Diazepam phlebitis (Letter to the Editor). JAMA 224:128–129, 1973

DAVID F. WEHLAGE, M.D.
South Bend, Ind.

SIR: In his Letter to the Editor Dr. Thigpen describes an interesting way of enhancing incomplete seizures or avoiding missed seizures through the use of intravenous pentylenetetrazol. I wonder if he has considered the far simpler procedure of monitoring the patient's EEG during the procedure with the type of operating room monitor available in most hospitals.

This kind of monitoring has several advantages (1–3) over the use of pentylenetetrazol, namely: 1) it avoids adding another drug unnecessarily; 2) it permits total paralysis of the patient during treatment; 3) it provides adequate definition of the seizure and therefore allows for better planning of further treatment; and 4) most available monitors permit simultaneous or at least alternate recording of the EKG.

REFERENCES

1. Blachly PH, Gowing D: Multiple monitored electroconvulsive treatment. Compr Psychiatry 7:100–109, 1966
2. Blachly PH, Semler HJ: Electroconvulsive therapy of three patients with aortic valve prostheses. Am J Psychiatry 124:233–236, 1967
3. Blachly PH: Electroconvulsive treatment compared with electrocardioversion: a source of ideas. Compr Psychiatry 9:13–30, 1968

PAUL H. BLACHLY, M.D.
Portland, Ore.

SIR: Based on his observation that some patients who responded poorly to ECT had incomplete seizures, Dr. Thigpen recommends the following procedures to produce full seizures: administration of 1) 8 cc. of a ten-percent solution of sodium methohexital intravenously; 2) 20 to 80 mg. of succinylcholine, "depending on the size of the patient"; 3) 5 to 8 cc. of pentylenetetrazol intravenously; and 4) after a wait of one and a half minutes, ECT.

Although Dr. Thigpen obtained his desired results with this procedure, it is not to be recommended because it is, in the main, potentially hazardous.

A dose of 800 mg. of sodium methohexital is a very large dose to use for ECT. It definitely raises the convulsive threshold, giving rise to partial seizures. The usual dose of this drug for ECT varies from 50 to 100 mg. All barbiturates depress the function of the heart and are especially dangerous in poor-risk cardiac and respiratory patients.

Succinylcholine should never be administered "depending on the size of the patient." It should be administered with the thought in mind that the dose is related to the patient's pseudocholinesterase titer. Some patients may become fully relaxed with only 5 mg. of succinylcholine while others may be sufficiently relaxed with 80 mg. The pseudocholinesterase titer may be estimated indirectly by performing the tendon-reflex succinylcholine test (1). Succinylcholine weakens or paralyzes the muscles. As a consequence, the tendon reflexes are abolished. Abolition of the ankle jerk indicates that the patient is fully relaxed. Abolition of the knee jerk indicates that he is sufficiently relaxed for ECT. With this technique the usual dose of succinylcholine is from 5 to 30 mg. Using individualized doses of succinylcholine avoids the dangers of prolonged apnea from overdosage and fractures from underdosage.

Instead of reducing the convulsive threshold with pentylenetetrazol, it would be better to avoid the increase of threshold produced by high doses of sodium methohexital. This could be done by reducing the amount given or by eliminating it altogether and using the PM-GM method of anesthesia (2). This method involves giving the patient two successive stimuli with the ordinary shock machine at 100 volts for one-tenth or two-tenths of a second.

It has been known for a long time that the convulsive threshold varies over different parts of the brain. It is highest at the frontal poles and diminishes as the electrodes are moved backward over the posterior temple region. The convulsive threshold is lowest over the motor area. If this is kept in mind, changing the position of the electrodes to the posterior temporal area or over to the motor area may produce adequate convulsions. When convulsions cannot be obtained with one stimulus, giving two stimuli a few seconds apart with the voltage and time set high will invariably produce adequate convulsions. When adequate convulsions cannot be obtained with the double stimulation, one had better examine the patient neurologically to rule out brain disease causing an increase in the convulsive threshold.

I believe that the above suggestions are consistent with a more physiological and safer method of producing effective convulsive treatment.

REFERENCES

1. Impastato DJ: Tendon reflexes as a guide to the safe use of succinylcholine in medicine. Can Psychiatr Assoc J 11 (Suppl): 67–77, 1966
2. Impastato DJ, Gabriel AR: PM-GM succinylcholine-modified electroshocktherapy without barbiturates. Am J Psychiatry 114:698–702, 1958

DAVID J. IMPASTATO, M.D.
New York, N.Y.

Dr. Thigpen Replies

SIR: I am dismayed to learn that there was a serious error in the typescript of my letter that I failed to catch. It certainly might be fatal if a ten-percent solution of sodium methohexital were given intravenously. The sentence in the third paragraph should be corrected to read: "The average patient is given approximately 8 cc. of a one-percent solution of sodium methohexital (Brevital)." I think it is urgent that this correction be made. I am indeed thankful to Drs. Simonson and Impastato for calling this to my attention. I am also grateful for Dr. Simonson's kind remarks. As he suggested, in the last sentence of the fourth paragraph I find that succinylcholine is the word I intended rather than pentylenetetrazol.

I am interested in the observation of Dr. Wehlage that a localized phlebitis is often caused by intravenously administered diazepam. In my experience, the incidence of phlebitis has been decreased by using a different vein each day the drug is administered.

I have never given diazepam as a premedication or as an amnesic agent for ECT. I have, however, wondered if the use of diazepam might prevent the effective induction of the neural convulsion. In administering thousands of ECTs using sodium methohexital, I have seen only occasional and inconsequential respiratory depression. I would be quite interested in learning more of Dr. Wehlage's technique in using diazepam as a substitute for our usual anesthetic agent. I hope that he will give us additional information.

In my experience, there has been far less postictal agitation with the administration of sodium methohexital than with other anesthetic agents I have employed. In the days when no anesthetic at all was used, the postictal agitation impressed me as being very much more frequent and more extreme.

I appreciate Dr. Blachly's and Dr. Impastato's comments. From a practical standpoint, observation of the patient seems to be sufficient in determining whether or not a patient is having a full seizure. The use of the EEG would provide an interesting experimental study.

The comments of Dr. Impastato, as one of the world's leading investigators in this field, are of interest and should be given due consideration. It has not been my experience that multiple stimuli can be counted on to "invariably produce adequate convulsions."

Perhaps the chief point of my letter would have been more accurately indicated by a title such as "Pentylenetetrazol with ECT" rather than by the one under which it appeared. The comment on succinylcholine was really incidental. My associates and I have been deeply impressed with the importance of using pentylenetetrazol as an adjunct to electroconvulsive treatment in a fairly large percentage of patients. In our experience, when the seizure reaction is too brief or abortive the therapeutic effect has usually been insufficient to bring about the usual progress and anticipated recovery.

Approximately 12 years ago I had two patients with depression and one with mania who were admitted to the hospital after having received a number of seemingly adequate treatments elsewhere. Despite further treatment these patients still showed no improvement. I noted in each one that the seizure was incomplete; the manic patient was in very serious physical condition due to exhaustion. I decided to try supplementary pentylenetetrazol in this patient, and the result was dramatic. The two depressed patients also responded to the addition of pentylenetetrazol with much longer and more typical ictal reactions and with rapid therapeutic progress. Before this time I had thought of using supplementary pentylenetetrazol with patients whose reactions to ECT were insufficient or incomplete and whose progress was unsatisfactory, but I had hesitated because I thought it might counteract the anesthetic effect of the barbiturate. It was most gratifying to find that this was not so. On the basis of subsequent experience with several hundred patients who have received supplementary pentylenetetrazol with ECT, I am convinced that it can be a crucially important part of successful therapy.

The above letters indicate to me that a full report supported by statistical data would be of great value.

CORBETT H. THIGPEN, M.D.
Augusta, Ga.

A Patient's View of Presenile Dementia

SIR: About two years ago I began to notice irregular memory lapses that lasted for only about a minute or two. As these lapses became more noticeable to me, my wife, and my children—not to mention my friends—I consulted the chief neurologist and the commanding officer of the local military hospital in my overseas post and asked their opinion on whether or not I might be subject to Pick's disease. This malady had caused my maternal grandfather's death at age 52 and possibly the subsequent death of my mother at age 47. No autopsy was made in her case, but the last time I saw her she could not recognize me. I have been told that a third generation of Pick's disease would be unusual.

I am aware that Pick's disease is rare and therefore on the back burner of medical research along with Alzheimer's disease. I am also aware that there is no effective medication to control the disease. (Please advise me if there is any effective medication.) My neurologist has prescribed levodopa (Larodopa) for me with no effect to date.

Optimistically, I have consulted two neurologists, a psychiatrist, a psychologist, and a local hospital, which administered EEG and brain scan tests that indicated "some irregularities." On the other hand, I find that my work is deteriorating; I find myself unable to make correct judgments under pressure.

In spite of my disease, I experience no pain and I usually exercise daily, including running a mile six days a week unless it rains. At the age of 45, I feel sound physically. On the other hand, I continue to have these minor, short-duration lapses of memory that, mercifully, cause me more embarrassment than anything else. At this point I feel somewhat like an absent-minded professor.

I have been able to acquire a listing of research on presenile dementia from the National Institute of Mental Health. This was reviewed by my neurologist. Based on his survey, there appears to be little or no effective research into this disease at present.

Since I continue to have regular memory losses, have exhausted my research into the subject, and am now eager to look for a new job and convince a prospective employer that it really does pay to hire the handicapped, I would wholeheartedly welcome news of any medications or procedures related to presenile dementia. I would volunteer to assist in such procedures within my ability to do so. I would be available to any physician interested in the causes and cures of this disease if it would be useful.

HARVEY ROBBINS
McLean, Va.

Editor's Note: Readers wishing to contact Mr. Robbins are invited to do so in care of the Editor of the *Journal*.

Early Childhood Illness and Choosing the Medical Profession

SIR: I was intrigued by the recent paper "Later Psychosocial Sequelae of Early Childhood Illness (Severe Croup)" (July 1973 issue), in which Dr. J.J. Sigal and associates examine certain hypotheses relating to the vulnerable child syndrome originally described by Green and Solnit (1). My response to this area of inquiry is both personal and professional and I wish to share both aspects.

At the age of nine years, I suffered a croup virus infection that required emergency tracheotomy treatment at a local hospital. Following the procedure, I was hospitalized on a pediatric ward for one and a half weeks and then recuperated at home for an additional two weeks. I was in the fourth grade of elementary school at the time and can recall aspects of my reentry into school after the traumatic event.

My memories of the acute infection, emergency medical evaluation, surgical procedure, events of hospitalization and postoperative care, and recuperative period remain painfully vivid. Prominent in my recollection are: my awareness of parental terror and my own fear of dying; my sense of being "attacked," with no way of escape, by well-intentioned physicians and nurses; my recurring experience of suffocation and pain associated with periodic tracheal suctioning; and my sense at the time of being abandoned and alone with no verbal means to communicate my distress. For years afterward, I had a recurring fear that the traumatic experience might happen again.

As I have made my way through medical training, psychiatric residency, and personal psychotherapy, I have reflected on the impact and influence of this experience on my behavior, on the goals and decisions I have made and continue to make, on the ways I typically respond to real or imagined danger situations, and on the vulnerabilities I am aware of. In a real way, this traumatic childhood event continues to affect my capacity to feel and express natural and appropriate aggressive impulses. How much of this handicap as well as others relates to my personal experience of this childhood disaster or to subsequent family processes influenced by it remains unclear to me.

I wish to indicate, however, that the experience has had some constructive dimensions. In subtle and complicated ways, it influenced my decision to pursue medical training and the formation of idealistic attitudes related to the practice of this profession. It contributed to a personal interest in working psychotherapeutically with persons who have serious life-threatening or life-afflicting illnesses. It has contributed to a professional interest in the hazards of physicianhood. In this latter regard, I have a personal commitment to appreciating the personal and family experiences that influence an individual's choice of medicine as a career and the kinds of vulnerabilities these experiences might continue to exert in the individual's practice of his or her profession. It would be intriguing to me if the experience of a life-threatening illness in childhood or the perception of such an illness in a significant family member ultimately proves to be one of the formative factors in the choice of medicine as a profession.

REFERENCE

1. Green M, Solnit A: Reactions to the threatened loss of a child: a vulnerable child syndrome: pediatric management of the dying child, part III. Pediatrics 34:58–66, 1964

RANDALL WEINGARTEN, M.D.
Amherst, Mass.

Internship for Psychiatrists

SIR: The material that follows constitutes a portion of my thoughts regarding the position presented by Dr. Engel in his Editorial "The Responsibilities of Psychiatry to Medicine" (June 1972 issue). I hope that the *Journal* does not allow this issue to fade into the past without first permitting full discussion of the matter. The questions raised in the article are too fundamental and timely to be dismissed with routine attention. I anticipate that this subject will continue to be with us for a long time.

The *Journal* serves as the best vehicle for its exposure. It is certainly better in many ways than the annual meeting of APA or any task force meeting. In fact, a special issue of the *Journal* devoted to reviewing the recommendation that emerged from the Residency Review Committee when the controversy arose over the internship might be in order. The question of the internship requirement itself is but one issue in the more central topic of the responsibilities and aims of the profession of psychiatry.

Dr. Engel's concerns are most valid, and welcome. I believe he has identified a major danger in today's psychiatry, namely, the increasing blurriness of the role of the psychiatrist. The

common features that once held the profession together seem to be undergoing gradual and progressive erosion. As the modern psychiatrist relaxes in his comfort and apathy, the nonmedical professionals in the field usurp duties and responsibilities that properly belong within psychiatry.

While the elimination of the internship requirement may not truly expedite the complete education of the psychiatrist, it does expedite the fragmentation of the profession. This has been brought on by psychiatrists themselves. Once the profession is weakened, the related mental health disciplines will quickly fill in the vacuum, to nobody's benefit.

It seems imperative that the Residency Review Committee that recommended the elimination of the internship, later adopted by the American Board of Psychiatry and Neurology, reconsider this decision. They must reexamine the contextual circumstances that made such a decision possible. When I learned of the recommendation I wondered whether the desire to feel "up with the times" had something to do with it. The need to be "modern" and "socially relevant" can conceivably influence this type of decision-making process.

I will not disguise my desire to see the internship reestablished as an essential cornerstone of psychiatric education. I would also like to see psychiatric educators independently establish the internship as a requirement for psychiatric residency. While their residency programs might suffer from a short-term effect of diminished applications, time will generously compensate for it.

In this same vein, psychiatry should aim at taking a more effective position in helping define the limits of responsibility and competence for paramedical professionals in the field of mental health. Psychiatry should come to see this as a major inherent responsibility, both for itself and for the public it serves. Experience would indicate that zealous paramedical professionals, forced by voluntary and involuntary circumstances, assume responsibilities for which their disciplinary training has not equipped them. The deleterious effect this has on the public, on these various professionals, and on psychiatry can be judged by the individual reader. Even though defining these limits is not a pleasant task, I see no alternative if we are to continue to show interest in safeguarding the public and in advancing our profession. Legislation, institutional regulation, and a more action-oriented desire to serve are necessary.

Psychiatry is, and should continue to be, a fundamentally biological science. Psychological mechanisms are but one expression of the organism at work. Even if many psychiatric therapeutic interventions, e.g., psychotherapy, do not appear biological on the surface, these interventions are based on a sound knowledge of biological functions. The seasoned psychiatrist seldom thinks of this; rather, it becomes a part of his personal and professional identity.

Psychiatry can continue to contribute to medicine as long as the psychiatrist continues to have a clear understanding of the disease process. No experience better allows for acquiring this knowledge than the rotating internship. Space limitations restrict me to just this consideration, even though there are many other gains to be made from the internship experience.

As a young psychiatrist I have had the opportunity to work closely with psychiatrists who have not experienced an internship. Various aspects of their professional dealings show the effects of their "expeditious" training. As they act as consultants to other physicians, as they evaluate "somatic" complaints, as they grope to understand other medical and surgical treatments, the deficits become visible. It is irresponsible to train psychiatrists in this fashion.

I can only hope that psychiatry can come to reason and reinstate the internship. Only then can we hope to reunite forces to carry on our basic medical responsibility. Only then will we be able to speak in terms of real progress.

ALBERTO M. VARELA, M.D.
Philadelphia, Pa.

Id-Ego: Synergy or Antagonism?

SIR: In response to Dr. Terry C. Rodgers' discussion of Drs. Hochman and Brill's article "Chronic Marijuana Use and Psychosocial Adaptation" (February 1973 issue), I would like to state that Freud's dictum "Where id was, there ego shall be" (1, p. 80), implying as it does the concept of innate id-ego antagonism and in consequence the "admirable" pursuit of ego mastery, is only a slightly altered version of Freud's earliest statement on id-ego relations. Here the ego (actually ego-superego) embodies such Victorian "virtues" as pride, noblemindedness, and, above all, the demands of objective reality expressed in the need to feel and act "properly." "Disgust, shame and morality" (2, p. 178) were in perpetual draconian conflict with "endogenous sexual excitations" or, later, libido, which was then translated as any sexual activity or fantasy other than "proper" sex—even though Freud stated, in apparent contradiction, that the "disposition to perversions of every kind is a general and fundamental mental human characteristic" (2, p. 191).

Many, if not most, present-day analysts (with the notable exception of ego psychologists) subscribe to Freud's formulation of id-ego synergy rather than antagonism: "There is no natural opposition between ego and id; they belong together, and under healthy conditions cannot in practice be distinguished from each other" (3, p. 201); "If the ego remains bound with the id and indistinguishable from it, then it displays its strength. The same is true of the relation between the ego and the superego" (4, p. 111). I highly recommend Apfelbaum's exposition of this issue (5).

The latter of Freud's formulations suggests the possibility that the absence of identifiable neurotic symptoms in the chronic marijuana smokers could be precisely because of the absence of any significant split between ego and id, a situation that Freud (at least at times) considered the hallmark of maturity and mental health, rather than, as Dr. Rodgers stated, "closer to the perversions."

Freud can perhaps be forgiven his ambivalence about completely committing himself to id-ego synergy, since this would have amounted to a total repudiation of his Victorian formative years. However, there are compelling reasons for believing that this was Freud's definitive formulation of structural relations in mental health. His last word, published posthumously, was that "the power of the id expresses the true purpose of the individual organism's life" (6, p. 148).

REFERENCES

1. Freud S: New introductory lectures in psycho-analysis (1933), in Complete Psychological Works, standard ed, vol 22. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 7–182
2. Freud S: Three essays on the theory of sexuality (1905). Ibid, vol 7, pp 135–243
3. Freud S: The question of lay analysis (1926). Ibid, vol 20, pp 183–258
4. Freud S: Inhibitions, symptoms and anxiety (1926). Ibid, vol 20, pp 87–172
5. Apfelbaum B: On ego psychology: a critique of the structural approach to psychoanalytic theory. Int J Psychoanal 47:451–475, 1966

6. Freud S: An outline of psychoanalysis (1940), in Complete Psychological Works, standard ed, vol 23. Translated and edited by Strachey J. London, Hogarth Press, 1964, pp 144–207

CHARLES F. HESSELBACH, M.D.
New York, N.Y.

Dr. Rodgers Replies

SIR: I basically agree with Dr. Hesselbach regarding the vicissitudes of Freud's metapsychology. Space obviously precludes any exposition of my understanding of the meaning and relationship of the terms ego and id beyond stating that they are abstractions having dynamic, economic, genetic, and adaptive distinctions as well as structural ones. Freud, however, repeatedly warned against taking abstractions (especially extrapolated ones) too literally (1, p. 97; 2, p. 79). By implication this brings us to the question of context.

I used the quote under discussion in commenting on the chronic marijuana user's narcissistic self-evaluation, tribal submersion into the "drug culture," and active pursuit of unfocused, drug-stimulated sensations and perceptions. The institutionalization of this "cult of experience" seems to me to express a psycho-epistemology (method of awareness) devoted to the mystical proposition that *unintegrated* subjective experience is a state to be actively desired and pursued. I compared the psychodynamics of this drug-induced assault on the integrative and conceptual faculties to that of the perversions because to me it is behavior that is pathologic in terms of action rather than symptoms and because it expresses a conflict between *ego* and *reality* in which reality is "rewritten" to conform to id desires by ego splitting and denial. The split, in my opinion, is within the ego and not between the ego and the id.

To my old and good friend, Dr. Hesselbach, I would like to add that I am of the view that any time two analysts discuss a theoretical point you end up with three opinions.

REFERENCES

1. Freud S: Inhibitions, symptoms and anxiety (1926), in Complete Psychological Works, standard ed, vol 20. Translated and edited by Strachey J. London, Hogarth Press, 1959, pp 87–172
2. Freud S: New introductory lectures on psycho-analysis (1933). Ibid, vol 22, pp 7–182

TERRY C. RODGERS, M.D.
New York, N.Y.

Communicative Meaning in Capgras Syndrome

SIR: In 1923 Capgras and Reboul-Lachaux (1) described the rare clinical condition about which Dr. Haslam commented in "A Case of Capgras Syndrome" (April 1973 issue). Although Dr. Haslam referred to some historical origins of the syndrome, no psychodynamic information is provided, nor is there a description of any psychotherapeutic attempt that might have been made. Rather, the reader is told that a good remission has been maintained with fluphenazine decanoate, although "a letter dated October 22, 1971, suggests that she [the patient] still held to her underlying delusional belief."

In 1972 (2) I described the successful treatment of a 12-year-old boy (possibly the youngest case of Capgras syndrome in the literature). My therapeutic approach was directed toward removing the misidentification by viewing it as a concrete communication of conflicting affects.

Most of the theories about the basis for Capgras syndrome fall into three spheres: 1) as a function of perception; 2) as a function of thought and concept formation; and 3) as a communication. The third theory is most useful psychotherapeutically: in the face of unacceptable sexual or hostile feelings, an ambivalently held object is split into good and bad objects. The symptom repair, as explained by Rado, allows the patient to express his anger. The anxiety generated by the conflict stimulates errors in perception. Concreteness in thinking and faulty generalizations provide the convincing logic.

My patient responded within nine months to anxiety reduction with oral thorazine administered intermittently in doses of 150 gm. a day. He also responded to repeated interpretation to explain the syndrome in terms of the changing and conflicting feelings he had for his parents—the accused doubles. His symptoms were seen in the context of disordered communication in the family, and his parents were also treated psychotherapeutically. Along with the relief of interpersonal family tensions the need for the syndrome disappeared. Now, five years later, my patient remains symptom free and has recently been admitted to a leading university.

REFERENCES

1. Capgras J, Reboul-Lachaux J: L'illusion des sosies dans un délire systematique chronique. Bull Soc Clin Med Ment 11:6, 1923
2. Moskowitz JA: Capgras symptom in modern dress. International Journal of Child Psychotherapy 1:45–64, 1972

JOEL A. MOSKOWITZ, M.D.
New York, N.Y.

LETTERS TO THE EDITOR are welcomed and will be published, if found suitable, as space permits. Like other material submitted for publication, they must be typewritten double-spaced. The letters should not exceed 500 words, including references, unless a special arrangement has been made with the Editor, and they will be subject to the usual editing.

BOOK REVIEWS

Differential Diagnosis in Clinical Psychiatry: The Lectures of Paul H. Hoch, M.D., *edited by Margaret O. Strahl, M.D., and Nolan D.C. Lewis, M.D. New York, Science House, 1972, 802 pp., $20.*

This remarkable volume contains Paul H. Hoch's lectures on clinical psychiatry that were delivered to psychiatrists training in psychoanalysis at the Columbia Psychoanalytical Clinic for Training and Research. Approximately 20 years have passed since then, years that were extremely productive in many areas of psychiatry in the sense that new methodologies were developed. However, clinical psychiatry and differential diagnosis in clinical psychiatry are being neglected more and more in many highly sophisticated research efforts. Therefore, a book by a great clinician is most welcome at this time. It has no parallel in recent psychiatric literature. The editors, Margaret O. Strahl and Nolan D.C. Lewis, have done a great service to psychiatry, and their effort to reconstruct the lectures from tape-recordings and notes has proven highly successful.

The book starts with an elaborate discussion of the history-taking interview technique. The differences in interviewing psychotic and neurotic patients are stressed. In the second part alterations of consciousness, conception, and perception are dealt with.

Part 3 contains an extensive discussion of organic reaction states. Just as the physical organism responds with an inflammation to many different noxious agents, so does the human mind respond to different etiological agents with the same symptomatology. Most interesting are the possibilities of an interchange between organic states and an underlying functional psychosis.

In his earlier years in America Hoch's special interest was alcohol-caused psychoses. In the chapter dealing with this subject, treatment is given more space than in other chapters outlining physiological or medical, sociological, and psychiatric approaches. Other organic psychoses dealt with extensively are senile and presenile psychoses and epileptic and convulsive states.

The introduction to the chapter on functional mental disorders points out that their essential features are identical in all cultures. The differential diagnosis of depression and manic psychosis versus schizophrenia is particularly important in view of the present studies on diagnostic differences in various countries.

Hoch's close acquaintance with psychoanalytical concepts is revealed in his extensive—and critical—discussion of psychodynamic theories of depression. Hoch called it "painful" to tell students that we do not know the origins of the great majority of mental disorders, but said that it is better to admit this and to go on from there than to imply that we know something that we do not.

In a profound discussion of the different groupings and concepts of schizophrenia Hoch warned against the many attempts to subordinate some of the known facts for the purpose of accommodating one or another idea about the disease. The chapter on clinical manifestations of schizophrenia is, in my opinion, the best outline of the psychopathology of schizophrenia that can be found anywhere. It includes the formulations of Kraepelin and Bleuler, adding to them psychoanalytical, gestalt, and other concepts. Among the descriptions of the subtypes, the part on the pseudoneurotic type of schizophrenia, created by Hoch and Polatin, is, of course, of particular interest and should lead to a wider acceptance and better understanding of this important contribution.

In the final chapter on etiology Hoch summarized his own theory that schizophrenia has an organic matrix and is a special form of integrative impairment. For further research he encouraged separate pursuits in the chemical, epidemiological, psychodynamic, and social fields and suggested a critical attitude toward all attempts at integration for some time to come.

LOTHAR B. KALINOWSKY, M.D.
New York, N.Y.

On Dying and Denying: A Psychiatric Study of Terminality, *by Avery D. Weisman, M.D. New York, Behavioral Publications, 1972, 237 pp., $9.95.*

Our society appears to be riding the crest of a wave of concern for the problems of dying persons. Perhaps this concern has been generated by a threat to our sense of immortality, which Robert Lipton ascribed to nuclear weapons. Perhaps it reflects the reassertion of humanistic values that we see occurring all around us and that, within the medical profession, we see taking the form of renewed interest in the dying person's human experience apart from his terminal disease. Perhaps, also, a growing concern within the profession has been provoked by the ethical dilemma—between preserving life and relieving suffering—that technological advances have thrust upon us.

In any event, the growth of this near-subspecialty in the past decade is truly remarkable. Professional societies have been established to further knowledge in this area and two journals, *Omega* and the *Journal of Thanatology*, are devoted exclusively to the subject. Indeed, the number of books and articles now devoted to thanatology exceeds the devotion and energy of even the specialist in this area.

A change in attitudes toward dying patients is long overdue. According to Seneca, we die not because we are sick, but because we are alive. This ancient bit of wisdom has gone unheeded by physicians, who have labored to sustain life as though death were conquerable and as though their dying patients were mere conglomerates of failing organs. The psychiatric contribution to the care of dying persons will come through an understanding of the psychological process of dying.

It is here that Dr. Weisman's book is an outstanding contribution. As its title implies, the author focuses upon a central aspect of this process—denying. The question most frequently raised by those who care for dying patients is what to tell them about their prognosis. Dr. Weisman, from his rich experience and study of dying persons over more than a decade, shows the irrelevance of this question. He tells us that the denial so universally encountered among these patients is not a static defense, as we are accustomed to thinking of it, but rather one aspect of an adaptive process by which dying persons gradually come to grips with their death.

Dr. Weisman describes opposing tendencies in dying patients. An inhibitory one, of which denial is a part, limits perception of the disturbing reality through avoidance and postponement. A facilitative one enhances perception and thought about this reality, thereby allowing drastic changes in identity and orientation toward life to take place. These tendencies oscillate over time and are influenced by the physical decline and progressive

change in interpersonal relationships experienced by dying persons.

Dr. Weisman eloquently illustrates his thesis with case reports, from which the humanity of his dying patients shines through. Despite his at times distracting habit of naming the various phases and stages, his concern for preserving the uniqueness of persons as they die remains abundantly clear. He stresses that those in caretaking professions should strive to preserve even the rudiments of responsible choice for their dying patients, which is, after all, the essence of their humanness.

In a number of chapters Dr. Weisman departs from the main theme of his book and explores certain emotional and social precipitants of death. He neglects the data that link bereavement to increased mortality, where a discussion of this subject might well begin. However, he makes it clear that a variety of emotional and social factors influence not only the quality of life but the timing of death for many dying patients.

Finally, Dr. Weisman tells us that acceptance of death is not only a possible but a desirable end to the process he describes. It is no achievement for those of us in good health. Rather, it is born of the weariness of terminal disease and a narrowing of attention to the current moment, from which vantage point the dying person may experience his being as timeless and his uniqueness as enduring.

RUSSELL NOYES, JR., M.D.
Iowa City, Iowa

Personality Differences and Biological Variations: A Study of Twins, *by Gordon Claridge, Sandra Canter, and W.I. Hume. Elmsford, N.Y., Pergamon Press, 1973, 168 pp., $11.40.*

In this compact monograph a group of enthusiastic investigators working at the University of Glasgow make good use of a sample of 95 pairs of twins to test out some of the senior author's psychophysiological hypotheses on the classification of personality. At the same time an effort is made to estimate the contribution of heredity to variations among people in each of the tests, measurements, or statistically derived personality factors under consideration.

The classic twin method—comparison of monozygotic and dizygotic twins, with its value and limitations—is well described in an introductory section and then applied in successive chapters to personality traits, cognitive function, physiological measures, and tolerance to sedative drugs.

There are some interesting findings. Sandra Canter points out, for example, that a personality trait, such as sociability, may have important genetic determinants but that these can be masked, as long as the twins live together, because of mutual interaction and the assumption of complementary roles; the twins become more alike after they are separated. In another area, tests of cognitive function seem to indicate that general intelligence is most influenced by heredity and that creative thinking is correlated with intelligence (and hence genetically influenced) only up to a certain IQ level. In this area, however, the age and separation of the twins seem to increase the differences between them.

Physiological measures and sedation threshold are analyzed individually, and the data are then subjected to factor analysis. Two principal factors are isolated—one involves activation (sedation threshold and heart-rate level) and is termed "tonic arousal," and the second is concerned with regulation (EEG alpha activity) and is termed "arousal modulation." It is the latter that seems to be more influenced by heredity. Both of them form the parameters of Claridge's descriptive model of personality, with two major dimensions—neuroticism and "psychoticism."

The mere clinician may question the usefulness of such elaborate methods of describing personality, but typology has a long history in psychiatry, and efforts to define dimensions and measure them deserve his attention. For dessert, he may enjoy the brief vignettes, in chapter 7, of the four monozygotic twin pairs with high degrees of discordance, particularly on tests of creativity, and speculate on the design of prospective studies to learn how such divergent spirals grow.

This book reports an elaborate, tightly argued, and clearly presented study that not only will be of interest to the specialist but ought to refine clinical observation and stimulate ideas among psychopathologists of all disciplines.

JOHN D. RAINER, M.D.
New York, N.Y.

The Victim Is Always the Same, *by I.S. Cooper, M.D. New York, Harper & Row, 1973, 160 pp., $6.95.*

Dr. Irving S. Cooper is world-renowned for his revolutionary discoveries of neurosurgical approaches to the treatment of Parkinson's disease and other extrapyramidal disorders as well as for his pioneering work in the field of cryogenic surgery. His interests for years have transcended his profession, and he has written many high-quality articles relating to the various fields of literature, history, and medicine. In this brief monograph he plunges boldly into medical-ethical issues and problems that confront not only physicians but also patients and their families.

When his latent yet mostly blatant criticisms of certain psychiatric practices and attitudes are encountered for the first time, any psychiatrist is apt to feel like a young person just soundly spanked. In the final analysis, however, the reader will find himself thoroughly educated about the condition of dystonia musculorum deformans, and it is to be hoped that if he ever encounters the disorder in his practice, he will not miss the diagnosis.

In a humanistic, autobiographical style Dr. Cooper takes the reader step by step through the process of encounter, diagnosis, management, and final, almost total, symptomatic relief of two young persons who were afflicted with this rare form of dystonia. The text is highly emotional in tone, and the reader cannot help but be moved by a variety of feelings as the story unfolds.

There is little question that Dr. Cooper tries very hard to hide his justifiable, righteous indignation toward what he deemed psychiatric mismanagement of his young patients. He specifically states that he does not purport to indict or criticize psychiatry in general. However, in these days of increasing need for peer review and self-assessment, Dr. Cooper need not have been so apologetic. The whole issue was simply that some psychiatrists missed the diagnosis and, undoubtedly in good faith but with some ignorance, tried to treat these children with psychotherapy, multiple drugs, and unnecessary hospitalizations, the latter resulting in much expense to the patients' families in terms of time, money, and emotional trauma. Dr. Cooper is faulting only these psychiatrists' myopic diagnostic approach and resultant mistakes in clinical judgment as he laments the consequent dehumanization of the patients and their families.

Although the author did not intend to write his book primarily for the medical reader, it is a book to be highly recommended for all psychiatrists, internists, neurologists, neurosur-

geons, pediatricians, and family physicians. The author's point is well taken, and psychiatrists in particular have much to learn from it.

The book can be read quickly; it is stylistically well written. One example of the author's sincerity and warmth appears in the preface:

> I should have wished to write a poem had I been able, for perhaps in poetry one could compress the strength, maturity, courage, loneliness, torment, despair, effort, faith, humanity, of these children. In their condition is the distillate of human authenticity. In spite of the condition inflicted upon them, they remain loyal to life and to themselves.

Dr. Cooper raises one other important moral-ethical issue, namely, who has the right to decide which person is to be operated upon and which is not when the newly developed and previously untried surgical procedures carry not only possibilities of relief from suffering but unknown risks as well?

Another reward gained from reading this book is the feeling that one has just rendezvoused with genius.

WILLIAM W. ZELLER, M.D.
Hartford, Conn.

Manuel de Psychiatrie de l'Enfant, *by J. de Ajuriaguerra. Paris, Masson & Cie, 1970, 1023 pp., 180 F.*

This imposing volume, by a distinguished Spanish-born neurologist and psychiatrist, is the result of the author's effort to present the material from his courses offered to medical students in a comprehensive handbook. In view of the vastness of this endeavor, only some highlights and the author's general orientation can be discussed here.

In the introductory chapter, child psychiatry, through the confluence of various disciplines, is defined as "a genetic psychopathology which deals with development and its deviations and which, knowing the genesis of functions and their evolution in time, focuses on the importance of the possibilities of the child at each level of his evolution and aims at understanding the various phases of this chronology in the light of the relationship between the organism and the environment." Although the polarization of organogenesis and psychogenesis cannot be easily overcome, the author shows how the succeeding maturational levels and functional realizations of the child take place along a developmental schema that unfolds itself in space and in time and in which "there is room for the lived and for the imaginary, without the lived taking a mythical meaning and the imaginary a disembodied meaning."

Perhaps the greatest merit of this volume, especially for the American-trained child psychiatrist, is that it presents a broad theoretical model in which either the organogenetic or psychogenetic data can receive the emphasis according to the specific clinical problem. For those too committed to a particular frame of reference (far too many, alas, on this side of the Atlantic!), the chapter dealing with the principal genetic theories of the development of the child of Freud, Wallon, and Piaget is particularly refreshing for its clarity, depth, and objectivity. In concluding this chapter the author states that "these three doctrines show us various ways which make it possible to better understand the development of the child. We believe that each one of them offers essential notions and that an attitude of compromise would be detrimental." Three other chapters, on the social life and development of the child, general problems of development, and general problems posed by the psychological disorganization of the child, are included in the first part of the volume.

The second part of the book deals with sleep and its disturbances, the oral-nutritional areas, the organization of psychomotility and its disturbances, the organization of sphincteric control and its disturbances, the organization and disorganization of language, the development and disorders of body image and of self-concept, the development of sexuality and its deviations, and the psychopathology of aggressive impulses.

In contrast, and perhaps not entirely in harmony with the developmental emphasis of the preceding section, part 3 deals with the problems of premature children, affective deprivation, mental deficiency, organic brain syndromes, and various neurotic, manic-depressive, psychotic, and psychosomatic conditions. The author has attempted to break away from the fragmentation of the clinical pictures by grouping them under the overall term of "syndrome." He has included syndromes of mental deficiency and of brain disorders of various etiology in the overall field of child psychiatry, a trend shared by other European comprehensive presentations.

Finally, part 4 is dedicated to the child in relation to his environment and deals with the child and his family, the child and the school, the child with a physical handicap, the child and the adolescent in society, and the abused child in the context of his family and his environment. Many readers will feel that a good part of this material, being of relevance to all children, should have been presented earlier in the volume, in line with the greater role attributed to the environment by American child psychiatrists than by their European colleagues.

Even more important than this is the small role that therapy in general, and psychotherapy in particular, is given in the volume. There is no general presentation of psychotherapy; instead, a brief discussion of therapeutic procedures is given at the end of some of the chapters, i.e., those dealing with epilepsy, enuresis, and speech disorders. In this work of more than 1,000 pages only a few pages are devoted to therapy, and the words "therapy" and "psychotherapy" do not even appear in the index. Perhaps more than anything else, this illustrates the principal difference between the European approach, which focuses on etiology and symptomatology, and the American approach, which aims at an empirical therapeutic intervention at a personal and environmental level for the emotional disturbances of children.

Be this as it may, there is no question that Professor de Ajuriaguerra's volume, which also contains an excellent, international bibliography, will soon be placed among the comprehensive textbooks of the classic medical tradition.

GEORGE MORA, M.D.
Poughkeepsie, N.Y.

On the Psychology of Women: A Survey of Empirical Studies, *by Julia A. Sherman, Ph.D. Springfield, Ill., Charles C Thomas, 1971, 296 pp., $13.50.*

The title indicates the purpose of this book. In the preface Dr. Sherman warns of the "empirical density" of the book and suggests reading the chapter summaries and final chapter as a means of learning the content of the book. For very hurried and serious-minded readers this may be sufficient, but they will miss the flavor of the book and Dr. Sherman's delightful comments. For example, "Androcentric bias is certainly reflected in the Freudian hypothesis that having a baby represents compensation for lack of a penis. As seen in Chapter 3, there is little

to support this general line of thinking, though no study bearing directly on Freud's sour grapes hypothesis was found." However, even the hurried reader will catch her statement that "For the normal girl and woman a baby is a first-choice item, not a consolation prize."

The prodigious amount of reading and comparing of research methods, data, and results incident to writing this book is overwhelming. It is astonishing how many research studies reached definite conclusions about women on the basis of studying ten to 50 women, usually from white, middle-class society. The supply of potential research subjects is so great and has been around so long that it is amazing how little is known and how much presumed.

The facts at hand show that there is a difference, from fetal life to death, between males and females. But there are also similarities that lead inevitably to the conclusion that the members of both sexes are people. What is not clear is which of the characteristics of each group are people-determined and which are sex-determined. Both differences and similarities are physical, physiological, and psychological. The mystery of hormonal effect and the extent to which performance is affected are still more a matter of opinion than of science. The evidence that social and psychological attitudes affect a woman's reproductive functioning is clear, but the assumption that all reproductive malfunctioning is of psychologic origin is far from proven.

The survey raises questions about the proof of the worth of "natural" childbirth and breast-feeding. Dr. Sherman casts doubt on the fairy tale that to women in primitive cultures childbirth is merely a pause in the day's occupation. Furthermore, the return to "natural methods" has not been proven to result in better child care, and there has been some indication that, for some women, there is a gestalt in their reproductive functioning that forecasts their level of child nurturing. "Research on mother variables seems to be relatively neglected, and at this point it might well be more productive of improved child health than would increased child study."

This book is worth careful reading. For some readers it will be a shaking experience to face the number of mere assumptions that have been taken as truth. It is to be hoped that the book will inspire some research scientists to begin questioning some of the unproven assumptions about women. By design, the data and bibliography are so presented that each reader can reexamine the material and reach his own conclusions.

MABEL ROSS, M.D.
Chicago, Ill.

The Drug Abuse Controversy, *edited by Clinton C. Brown, Ph.D., and Charles Savage, M.D. Baltimore, National Educational Consultants, 1972, 270 pp., $8.50.*

This volume is the report of a symposium that was held following the passage of the Comprehensive Drug Abuse Prevention and Control Act of 1970. The contributions are too numerous to detail individually; most are excellent, a few ordinary. But, overall, they present a timely, controversial image of *The Drug Abuse Controversy.*

At the symposium Sonnenreich explained the 1970 law and its reforms, particularly the fact that it distinguished between possession of and trafficking in drugs. Freedman responded, saying that he felt that any bill that gave the attorney general initial and final authority to decide on legitimate medical practice was a "throwback in history." He favored enforcement but not preoccupation with "pharmacological original sin," and he stressed the role of social custom in drug use as well as "the impossibility of absolute control over what is going on" by any group or individual.

Robertson considered the problems of overcriminalization of drug laws. He predicted that the new law would provoke more drug use, more police power, and more controversy (there hardly seems less). He would replace "the formal restraints of law" with "informal controls naturally present" in the daily context in which drugs are used. He felt that the tendency to unduly use and rely on criminal law to solve moral, social, and political problems has had "very little effect on what people do" but a very "adverse effect on law itself" because the disaffection for drug laws spreads and becomes a disaffection for the rule of law in general. Attempts to enforce bad drug laws drain police manpower and judicial and correctional resources.

Cohen replied and found Robertson's suggestions no less unsound than the efforts to legislate human behavior, which he decried. In addition, he said that without criminal laws to regulate drug use we would return to the "good old post-Civil War days" when four percent of the population was involved in an opium or morphine habit.

Szasz regarded self-medication by adults as a fundamental right that should not require medical approval. The individual then assumes unqualified responsibility for his drug-intoxicated behavior, because drug addiction is a moral problem rather than a medical question. (During an earlier era of drug prohibition, "prescription whiskey" failed to answer a similar medical question.)

Starratt described the possible role of affluence, permissiveness, and boredom as factors in drug abuse. Economic security alters the concept that the great satisfactions of life must remain a distant goal. As Starratt noted, "If you can try anything, if you can have everything, then the easily accessible is no longer exciting and escape from the ordinary is possible only by trying something which is generally forbidden. Very often among urban youngsters it is drugs."

Savage and McCabe reported on psychedelic (LSD) therapy of drug addiction. Their preliminary results indicated that such therapy is a safe, short-term method of rehabilitating the chronic hard-core heroin addict, but they fear that "future research activities in this area probably will be determined more by social-political attitudes than by scientific considerations." Savage observed that "from the moral position it is difficult to see why methadone is good and heroin is bad . . . it is equally unclear why it is good to be given methadone by an ex-addict narcotic counselor and bad to be given methadone by an ex-addict narcotic pusher."

JACKSON A. SMITH, M.D.
Maywood, Ill.

Transcultural Research in Mental Health, vol. II of Mental Health Research in Asia and the Pacific, *edited by William P. Lebra. Honolulu, University Press of Hawaii, 1972, 423 pp., $14.*

This excellent volume contains the carefully prepared papers presented at the second conference on Mental Health Research in Asia and the Pacific held at the University of Hawaii's East-West Center in 1969. The papers offer a comprehensive, multidisciplinary, and scholarly review of a wide spectrum of studies and general issues in transcultural research in Taiwan, Korea, Japan, Hawaii, Java, Thailand, the Philippines, Viet Nam, and Malaysia.

Specific papers consider problems of family dynamics, socialization, personality development, an epidemiological survey in

the Philippines, and comparative studies of specific symptom patterns as well as religious healing in a Buddhist hospital in Thailand and in Javanese mystical groups. More general papers consider problems of cultural change, migration, expatriation, and student adaptation abroad.

Despite the general acknowledgment of the value of a culturally integrated context for individual psychological development and maturation, there was general agreement that a universal definition of pathology could be developed, taking into consideration the cultural significance of specific symptoms. The need for defining measurable behavioral units that could be cross-culturally studied was considered. Sick-role theory, for example, was considered in terms of its value for understanding cultural responses to specific illnesses. Similarly, cross-cultural studies were thought to be especially valuable in examining such specific phenomena as cultural change, sociocultural disintegration, population increase, technological development, migration, youth protest, revolution, anomie, and other broad patterns of behavior.

A highlight of this volume is the section devoted to epistemology. Here Gregory Bateson examines epistemological problems, Jerome Frank discusses group perceptions and relations, and Thomas Scheff examines the political dimensions of psychiatric thought. These articles emphasize that the concepts of health and illness are loaded value concepts with different significances in different cultures. These epistemological issues raise serious considerations for psychiatrists interested in social change and its effects on behavior. Thus, as Leighton points out in his summary chapter, social change may modify the nature of justice within a social system with a relative neglect of issues of justice, which he suggests may be more important for maintaining stability of institutions and growth and progress.

I strongly recommend this book, especially to those interested in specific substantive issues such as ethnicity and social change and to those interested in learning more about the sophisticated methodologies currently being applied in this broad-gauged field of transcultural psychiatry.

ARI KIEV, M.D.
New York, N.Y.

The Manipulator: A Psychoanalytic View, *by Ben Bursten, M.D. New Haven, Conn., Yale University Press, 1973, 267 pp., $10.*

When a thing is manipulated, a degree of skill is involved, as, for example, in the case of a pilot managing the controls of a plane. But to manage a person artfully in what is known as manipulation would not be looked upon as salutary, since it implies pulling out all stops to one's own advantage, as illustrated by the synonyms "juggle," "falsify," "handle," etc. Also implied is a shrewd use of influence, especially in an unfair or fraudulent way. But, as is noted in the preface of this book, manipulative behavior is probably a reflection of neither inner goodness nor badness, but of inner humanness. Everyone manipulates to some degree, and I was pleased to find "The Psychiatrist as Manipulator" as a chapter of the book.

The psychoanalytic view finds the reasons for the manipulator's behavior in examining the child at his mother's knee. Bursten uses case histories liberally to detail the characteristics of manipulative behavior, which are: a conflict of goals between the persons involved, intentional behavior and deception on the part of the manipulator, and exhilaration at having "put something over."

The author, a faculty member of the department of psychiatry at Yale University, describes the manipulative person and the confusion he creates in all walks of life, especially in the hospital. The author goes into the derivation of this behavior in largely unconscious mechanisms and outlines some courses of therapy; the spectrum of treatment ranges from psychoanalysis to group therapy and the therapeutic milieu.

The height of manipulation is observed in the antisocial personality. In putting something over, such a person uses others to an end rather than relating to them as human beings; he has no loyalty to the other person. The psychopath or sociopath manipulates people with Machiavellian skill as though they were things, and he becomes especially adept in choosing tolerant persons who cooperate. This extreme manipulation usually involves criminal offenses, and this is not the particular thrust of Bursten's endeavor; rather, he considers the manipulative person who might recognize his problem and want relief.

The analysis of the manipulative personality is looked upon as a part of the larger problem of the analysis of narcissistic personalities; reference is made to Heinz Kohut's book, *The Analysis of the Self* (1). The analysis of this characterological defense is very difficult and time-consuming. These persons are therapeutically elusive, and most forms of therapy are not particularly useful in resolving their firm defenses.

The book represents a nice study of manipulative behavior from the vantage point of the libertarian psychoanalyst. Without the need to judge critically, there is firmness in the approach; a concern for the dignity of the patient is tempered by the expectation that with assistance the goal for the patient is to become responsible for whatever it is that he is pleased to do.

In the preface the author pays tribute to his mentor, Dr. Maurice Levine. Those who knew this fine teacher will see Bursten's book as a natural derivation of a thoughtful and appreciative pupil.

REFERENCE

1. Kohut H: The Analysis of the Self. New York, International Universities Press, 1971

CHARLES D. ARING, M.D.
Cincinnati, Ohio

Talent and Genius: The Fictitious Case of Tausk Contra Freud, *by K. R. Eissler. Chicago, Quadrangle Books, 1971, 395 pp., $12.95.*

Polemics are an unhappy but inevitable accompaniment of all human enterprises, including the sciences. Sometimes these disputes are illuminating, although one might wish that other modes of clarification could have been chosen. The present volume is, in fact, informative and thought provoking, although it is bred of one of the many disputations by which psychoanalysis has been held under attack since its beginnings.

Talent and Genius is a response to and rebuttal of Paul Roazen's *Brother Animal: The Story of Freud and Tausk* (1). Victor Tausk was a brilliant but unstable member of the group that studied with Freud during the second decade of this century. His paper on the "influencing machine" (2) is a classic in psychiatric annals, and other papers have had wide acceptance. In 1919 he committed suicide. Roazen suggested that Freud was indirectly responsible for this by reason of his jealousy and insecurity in the face of this highly able student and that, further, there has been a conspiracy of silence to keep this hidden. Eissler, as the secretary of the Freud Archives and by virtue of his preeminence as a creative and respected contributor to psychoanalysis, was a natural person to undertake to set the record

straight. Roazen, I might add, has in turn responded with an 11-page answer to the "denunciation" of his scholarship, published in a journal that is unfortunately unknown to more than a few psychoanalysts, psychiatrists, and psychologists (3).

The towering figure of Freud has long been a target in ad hominem arguments directed against psychoanalysis. The generator and originator of a science is rejected or ignored because he disturbs the repressive barrier, is minimized because his work is after all built in part upon historical precursors, and is denigrated because of alleged character flaws. I speculate that the popularity of such "debunkings" of historically great figures is peculiarly a consequence of certain democratic institutions that place great leaders within easy psychological accessibility to the envy, ambition, and competitiveness of the oedipal masses. This is not to reduce all such historiography to unresolved ambivalence toward the father, but only to say that it is a factor to be considered. Indeed, any work of scholarship must be judged on its own merits. In such a context, the Tausk-Freud issue is resolved by Eissler's superior array of facts.

I would like to point out, however, that this book is valuable beyond the polemics in which it is engaged. It is a book for browsing in, for it abounds in useful and provocative psychological insights—regarding not only Freud, the genius of the title, but also such matters as the psychology of the analyst, the charisma involved in the successful treatment of psychotics, the uses and dangers of the rescue fantasy in the motivations of the analyst, and a notable and far-ranging discussion of the psychology of genius.

REFERENCES

1. Roazen P: Brother Animal: The Story of Freud and Tausk. New York, Alfred A Knopf, 1969
2. Tausk V: On the origin of the "influencing machine" in schizophrenia (1919). Psychoanal Q 2:519–556, 1933
3. Roazen P: Reflections on ethos and authenticity in psychoanalysis. The Human Context 4:577–587, 1972

STANLEY L. OLINICK, M.D.
Washington, D.C.

Uncommon Therapy, *by Jay Haley. New York, W. W. Norton & Co., 1973, 313 pp., $8.95.*

The subtitle of this book is *The Psychiatric Techniques of Milton H. Erickson, M.D.* Haley says in the introduction that most of the writing is his and that the case material was taken from Erickson's writings and from tape-recordings of conversations with him. The book is a "joint product" of their meetings over 17 years (p. 9). Despite this collaboration, "the point of view generally expressed in this work is not necessarily that of Dr. Erickson" (p. 12). The latter read and approved of the manuscript, "but his own view of his therapy is expressed in his own writings." Haley says that he has not offered a critical review of the work and has not emphasized his disagreements with Erickson. He realizes that "some readers may be irritated by the continual emphasis upon successful treatment in this work" (p. 12). He explains, "Generally, Dr. Erickson describes his approach with remarkable clarity, at times adding a touch of drama, since he tends to see the world in that way. Often he likes to present the problem he was faced with as an impossible one and then reveal the solution" (p. 13).

The book has chapters on "Strategic Therapy," "The Family Life," "The Courtship Period: Changing The Young Adult," "Character Revision Of The Young Adult," "Marriage And Its Consequences," "Childbirth And Dealing With The Young," "Marriage And Family Dilemmas," "Weaning Parents From Children," and "The Pain Of Old Age." Haley has been interested in the family and family therapy, and the chapter titles and basic approach reflect this interest. Erickson is known primarily as a hypnotherapist. Haley uses the clinical material to fuse both interests. Not all of the data are derived from hypnotherapy. The account is laudatory. Haley seems to stand in awe of Erickson. "He has long been known as the world's leading medical hypnotist. . ." (p. 18). Haley may perhaps know Erickson's reaction to this type of praise, which sounds like a publisher's blurb.

Readers who are not acquainted with Erickson's work with hypnosis may wonder about direct access to it. I believe they would do well to read his journal articles, and his writings of the 1930s and 1940s, some of them coauthored, should also be helpful. Unfortunately, there is no bibliography. Furthermore, there is no attempt to integrate in any significant way the data given here with those of Erickson's colleagues. In addition, there is no index.

Haley supplies an epilogue, and its tone reflects his overall approach to the personality and content of this volume:

> In his later years his approach to human problems has a simplicity and efficiency that reminds one of the later work of many artists. Picasso achieves more simplicity in his drawings, Borges turns to a more elementary way of telling stories, and Erickson has mastered an economy of therapeutic style, perhaps compensating for his increasing physical weakness, which is like the strokes of a diamond cutter.

JEROME M. SCHNECK, M.D.
New York, N.Y.

The Farther Reaches of Human Nature, *by Abraham H. Maslow. New York, Viking Press, 1971, 417 pp., $12.50.*

Socrates sought to comprehend truth, Darwin to understand evolution, and Freud the effects of the unconscious. The late Abraham Maslow sought to understand the self-actualized man. During his career as a psychologist his focus turned from animal research to the investigation of the *healthy* aspects of human nature. Maslow asked: What are man's potentials as a human being? What can he become if not shackled by neuroses? To what heights is it possible for man to transcend? To find answers Maslow sought out and studied those rare specimens among us who seem to transcend the sickness of our culture and become God-like in the actualization of their potentials.

Maslow has been criticized for "breaking the rules of scientific investigation." But Maslow, the scientist-philosopher, reexamines the premises of modern science and finds them inadequate for the full understanding of man. With tongue somewhat in cheek, he defines modern science as "a technique, social and institutionalized, whereby even unintelligent people can be useful in the advance of knowledge."

To comprehend the self-actualized man, Maslow is forced to revise the techniques of research and to expand the boundaries of our language, introducing "instinctoids," "peak experiences," "B-Cognition," "B-Values," "metaneeds," "metapathologies," etc., in order to conceptualize the inner processes of human growth. He is concerned with values and spirituality not because he is a religionist, but because he found these elements to be characteristic of self-actualizers.

Maslow passes over (rather than angrily rejects) the medical model of mental illness to view neuroses "as a failure of per-

sonal growth." His concern is not with remediation but with prevention, with the expansion of inner awareness, with "full humanness." He points out that our psychological standards for normalcy are based on an unhealthy population, so that "normalcy" has become a "kind of sickness or crippling or stunting that we share with everybody else and, therefore, don't notice."

Normalcy should be based on the concept of what "ought to be" with man. And for Maslow, what man "ought to be" is only seen in self-actualizers. Such persons are free from severe neuroses, are in touch with their "interbiology" (instinctoids), enjoy a fusion of conscious and unconscious, and are dedicated to causes and to work (Being-Values) "outside their own skins." Because their primary needs are met they are intrinsically motivated (metamotivation). Through peak experiences they transcend painful self-consciousness, they reconcile within themselves problems of evil and death, and they achieve a fusion of facts and values, thus eliminating dichotomizations.

The present volume contains the cream of Maslow's life-long study of the healthy human being. As with his other writings his style is both humorous and clear and his insights profound.

For the mental health specialist whose professional reading is normally confined to journals and scientific books, *The Farther Reaches of Human Nature* will provide provocative reading and stimulate a reevaluation of professional goals. In a very real sense, Maslow's book is therapy for the therapist.

RICHARD C. SWEETLAND, PH.D.
Overland Park, Kans.

Hallucinogenic Drugs, *by F. Christine Brown, Ph.D. Springfield, Ill., Charles C Thomas, 1972, 147 pp., $10.50.*

Hallucinogenic Drugs is a relatively brief literature review (salted with personal observations and professional judgments) of hallucinogenic drugs, which are organized into classes based on the similarity of their chemical structure. The book contains chapters on phenylalkylamines (mescaline, amphetamines), lysergic acid derivatives, indoles, marijuana, and piperidyl benzilate esters (Ditran). It also includes a short introductory chapter on terminology and drug use and a chapter on some miscellaneous intoxicants. The chapters all have references to the research literature and are divided (inconsistently) into sections dealing with chemical topics, pharmacology, clinical observations, and other subjects, which are discussed in an informal style. The book has an adequate index, and the chemical formulas are clearly presented. However, it contains an unusually large number of typographical errors, uneven chemical nomenclature, and a few incorrect structural formulas (as of tyrosine and dopamine on page 14). It has one excellent color plate of a hemp plant.

The book was apparently intended as a stimulating introduction to the biochemical pharmacology of the hallucinogens at the freshman medical student level; I would not recommend it as an introductory text for specialists. It has some serious drawbacks, the most important of which is its brevity. The author has condensed an enormous literature into 147 pages, but to do this she had to sacrifice unambiguous exposition and a balanced selection of topics. Rather than focusing on a few particularly important or subtle topics, she generally chose to deal with a number of subjects at a breakneck pace. At several points (the discussions of the biosynthesis of mescaline and of LSD and model psychosis, for instance) I found her presentation confusing or misleading because of abrupt changes in subject or focus or overly brief analysis of complex problems.

Another drawback is that the author has made only a nominal attempt to integrate the subject matter of the chapters. Thus, structurally the book is an anthology of brief independent reviews; conceptually, this lack of coherence gives an almost anecdotal impression at some points and offers little basis for seeking or expecting integrating general concepts, fruitful comparisons of clinical experiences, or a sense of new directions.

However, the author is successful in presenting the problems and multidisciplinary nature of psychopharmacology.

JAMES L. MARINI, PH.D.
New Haven, Conn.

Rorschach Theory and Symbolism: A Jungian Approach to Clinical Material, *by Robert S. McCully, Ph.D. Baltimore, Md., Williams & Wilkins Co., 1971, 251 pp., $14.25.*

This year will mark the 51st anniversary of Rorschach's death. The publication of this text is propitious if for no other reason than its historical significance as a continuing tribute to the genius of Rorschach and his test.

This text is bold, innovative, and certainly unconventional, to say the least, in its efforts to apply Jungian concepts of archetypes to content analysis of each of the ten Rorschach plates. In historical retrospect Rorschach might have eventually written on this subject if he had lived. The paleopsychology of the Rorschach experience is certainly interwoven throughout his original text, *Psychodiagnostics* (1). His avid interest in comparative anthropology, art, and culture and his insightful speculations on the broader meaning of the *Erlebnistypus* as the keystone Rorschach concept so attest. Ellenberger's discussion of this (2, pp. 203–204) certainly suggests that it would have continued to be one of Rorschach's concentrated research efforts. Chapter 1 of this text, "Interlacing of Genius: Hermann Rorschach and Carl Jung," develops the speculation further. This text affords the Rorschach clinician a "comparative anatomy of the psyche," which Jung considered essential for all those interested in understanding associative content (3, p. 67).

Chapter 5, "Archetypal Influences in the Stimulus Plates," reads like a text in comparative anthropology in its detailed description of "certain common images that have come closer to us from Paleolithic and Neolithic artifacts" (p. 77) and that "have the power to link us with our remote past" (p. 75). The stimulus value of each of the ten plates is described in detail in "an attempt to locate components that provide it with the power to evoke in man, types of psychic sources" (p. 77). The experienced Rorschach clinician may feel less estranged in this chapter, since some of the classical inferences that are generally made concerning interest content and the stimulus value of some of the plates (e.g., cards 4 and 7 as the masculine and feminine, respectively) are explained in terms of their archetypal dynamics.

Chapter 8, "Nature of Rorschach Experience," deemphasizes the pathology in Rorschach imagery, which "has tended to produce a *set* ... which may do it an injustice" (p. 25). Rorschach data are not dream data, and the symbols evoked by the Rorschach extend beyond the usual libido theory of Freud. In short, "If the Rorschach experience does involve complex psychic behavior, archetypal influences must be around" (p. 30).

Although the author considers that it is "a distinct advantage to move through Rorschach material without a specific theory of interpretation" (p. 40), some comparative framework is still described in chapter 6—in the concept of "process analysis." A

schema is offered to describe a kinetic continuum of "disturbed processes or adaptive ones" (p. 172), "a sphere of movement between conscious awareness and symbol formation" (p. 173). This schema, the author himself admits, is a very general one (p. 177).

The illustrative case materials presented in chapter 7 are exotic and highly selected to illustrate the use of the Rorschach on the basis of their archetypal structures. Even though the interpretation is foreign to the classical Rorschach analysis and rejects the concepts of pathology and nosology, it would be helpful to at least present a "normal" subject for comparison. Some provocative questions could be presented. What is the relationship between the traditional Rorschach popular response in each card and its archetypes? How are the laws of symbol formation related to highly personal F minus responses? What are the developmental aspects of the Rorschach test on a longitudinal basis as related to the archetypal process (reference is made to Piaget's theories and to Ames's studies, on p. 244).

I have reviewed this text solely in terms of what it purports to do, i.e., to present a hypothetical method in the use of symbolism in the Rorschach test. To make it live up to Peotrowski's expectations that "eventually it will be improved in practice, systematized, and validated with gratifying results" (p. ix) will certainly require a Herculean and Sisyphean effort, to say the least. Yet this may be one of my own archetypal influences evoked by my own despair in viewing past efforts to objectify all that is subjective in projective test data.

REFERENCES

1. Rorschach H: Psychodiagnostics. New York, Grune & Stratton, 1949
2. Ellenberger H: The life and work of Hermann Rorschach (1884–1922). Bull Menninger Clin 18:173–219, 1954
3. Jung CG (ed): Man and His Symbols. Garden City, NY, Doubleday & Co, 1964

H. BARRY MOLISH, PH.D.
Houston, Tex.

Mental Retardation, An Annual Review: III, *edited by Joseph Wortis, M.D. New York, Grune & Stratton, 1971, 239 pp., $15.75.*

This third volume of the annual review of the field of mental retardation is a most valuable addition to our reference literature. The 12 articles vary in format. Some are brief surveys of the literature and apparently are not intended to be read but rather to be used as reference material if one wishes to do some more detailed studies, thus serving as a "Guide of the Perplexed" (Maimonides). Others are essays that reflect the opinion and sometimes the bias of the author. Others combine both aspects.

Articles that serve as guides to the more recent literature are those by George Jervis on "Neuropathology," Selma E. Snyderman on "Metabolism," Harold Diner on "Dentistry," James D. Block on "Operant Conditioning," and Carl Drayer and Gilda Guzman-Neuhaus on "Pediatrics." The comments of the authors are held to a minimum. These articles serve as excellent reference material. However, they make difficult reading even though the summarizations of the literature are most helpful and the bibliographies adequate.

At the other end of the spectrum are two excellent articles on "Residential Services" by Elsie D. Helsel and "Federal Legislation" by Elizabeth Boggs. Both essays are somewhat biased, and one may voice some disagreement with certain opinions expressed in them. After all, they mirror the authors' involvement and concern in the problems of mental retardation. But they give excellent surveys of where we were, where we are, and where we may go, and they make very good reading. One can read these essays without even referring to the literature. As articles they stand on their own merits, and their extensive references can be used as supporting material.

The balance of the material is a combination of the essay-type article and summary of reference material. These include the papers by Kirman on "Clinical Aspects," Knute Martin on "Guardianship," Eleonora Jedrysek on "Recent French Literature: Psychoeducational Aspects," Michael L. Rutter on "Psychiatry," and Joseph Wortis on "Prevention."

Rutter's article takes particular cognizance of the British literature. Jedrysek, as the title of her article indicates, reviews the French literature, but in addition she gives an excellent introduction into the French classification system and the general attitude and philosophy in dealing with the retarded in the French professional milieu. This is most helpful and widens the horizon of the reader. Rutter does not indicate that he is referring in particular to the British literature. However, he directs comparatively little attention to the American studies in this field. The British terminology and definitions in the field of mental retardation differ somewhat from the American semantics, and the reader will sometimes have difficulty in overcoming his confusion when reading the article. Both of these articles are valuable contributions and can be read with a minimum need for referring to the appendices or to the most adequate bibliography.

The same applies to Wortis' article on "Prevention." He not only summarizes and refers to the literature in guiding the reader through the maze but also forcefully expresses some of his own opinions and concerns. He closes his section on Medical Services and Prevention with the statement: "For us too, nothing less than the best and most comprehensive health services can build a base for the prevention of mental retardation." No one can fail to agree with this expression of Wortis' philosophy.

Some of the articles reveal a warmth, interest, and involvement in the field, such as Kirman's on "Clinical Aspects." Some raise more questions than answers, i.e., Martin's article on "Guardianship." And in others, as stated earlier, the reader may disagree with some of the statements, but they will challenge his thinking.

In summary, the general psychiatrist will benefit greatly from reading some or all of the articles in this volume. For the psychiatrist who is in any way involved in the field of mental retardation, this volume is a must.

BENEDICT NAGLER, M.D.
Lynchburg, Va.

This Month's Reviewers

LOTHAR B. KALINOWSKY, M.D., is Clinical Professor of Psychiatry, New York Medical College, New York, N.Y.

RUSSELL NOYES, JR., M.D., is Associate Professor of Psychiatry, University of Iowa College of Medicine, Iowa City, Iowa.

JOHN D. RAINER, M.D., is Professor of Clinical Psychiatry, Columbia University, New York, N.Y.

WILLIAM W. ZELLER, M.D., is Director of Psychiatric Education, Institute of Living, Hartford, Conn.

GEORGE MORA, M.D., is Medical Director of the Astor Home for Children, Rhinebeck, N.Y., and Research Associate, Department of History of Science and Medicine, Yale University, New Haven, Conn.

MABEL ROSS, M.D., is Professor, Health Care Services, University of Illinois School of Public Health, Chicago, Ill.

JACKSON A. SMITH, M.D., is Professor and Chairman, Department of Psychiatry, Loyola University, Stritch School of Medicine, Maywood, Ill.

ARI KIEV, M.D., is Clinical Associate Professor of Psychiatry, Cornell University, New York, N.Y.

CHARLES D. ARING, M.D., is Professor and Director, Department of Neurology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

STANLEY L. OLINICK, M.D., is Training and Supervising Analyst, Washington Psychoanalytic Institute, Washington, D.C.

JEROME M. SCHNECK, M.D., is in private practice; he is also Attending Psychiatrist, St. Vincent's Hospital and Medical Center of New York, N.Y.

RICHARD C. SWEETLAND, PH.D., is in private practice in Overland Park, Kans.

JAMES L. MARINI, PH.D., is Research Associate, Department of Psychiatry, Yale University School of Medicine, New Haven, Conn.

H. BARRY MOLISH, PH.D., is Chief, Psychological Services, Texas Children's Hospital, and Associate Professor of Pediatrics (Psychology), Baylor College of Medicine, Houston, Tex.

BENEDICT NAGLER, M.D., is in private practice in Lynchburg, Va.; he was formerly Superintendent, Lynchburg Training School and Hospital, Lynchburg, Va.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

The Act of Will, *by Roberto Assagioli, M.D. New York, Viking Press, 1973, 269 pp., $10.*

Recent Advances in the Biology of Schizophrenia, *by Thomas A. Ban, M.D. Springfield, Ill., Charles C Thomas, 1973, 105 pp., $12.50.*

Psychoanalytic Investigations: Selected Papers, *by Therese Benedek, M.D. New York, Quadrangle/New York Times Book Co., 1973, 528 pp., $15.*

Group Therapy for the Adolescent, *edited by Norman S. Brandes, M.D., and Malcolm L. Gardner, Ph.D. New York, Jason Aronson, 1973, 167 pp., $10.*

Orientation to Language and Learning Disorders, *edited by Mitchell R. Burkowsky, Ph.D. St. Louis, Warren H. Green, 1973, 278 pp., $14.50.*

Man for Man: A Multidisciplinary Workshop on Affecting Man's Social and Psychological Nature Through Community Action, *edited by John L. Carleton, M.D., and Ursula Mahlendorf, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 333 pp., $10.95.*

Motherhood and Personality: Psychosomatic Aspects of Childbirth, *by Léon Chertok, with M. Bonnaud, M. Borelli, J-L. Donnet, and C. Revault D'Allonnes. New York, Barnes & Noble (Harper & Row) (distributor), 1973, 294 pp., $3.50 (paper).*

Mental Retardation and Behavioural Research, *edited by A.D.B. Clarke, Ph.D., and A.M. Clarke, Ph.D. Baltimore, Williams & Wilkins Co. (U.S. agents), 1973, 274 pp., $18.75.*

Adolescent Psychiatry, vol. II: Developmental and Clinical Studies, *edited by Sherman C. Feinstein, M.D., and Peter L. Giovacchini, M.D. New York, Basic Books, 1973, 446 pp., $15.*

Pictorial Encyclopedia of Exercise for Health and Therapy, *by Dr. Edwin Flatto. New York, Pyramid Books, 1973, 254 pp., $3.95 (paper).*

A Bibliography of Noise, 1965–1970, *compiled by Mary K. Floyd. Troy, N.Y., Whitston Publishing Co., 1973, 373 pp., $17.*

Schizophrenia and Genetics: A Twin Study Vantage Point, *by Irving I. Gottesman and James Shields. New York, Academic Press, 1972, 415 pp., no price listed.*

Learning To Love, *by Harry F. Harlow. New York, Ballantine Books, 1973, 177 pp., $1.50 (paper).*

Drugs and Youth: The Challenge of Today, *edited by Ernest Harms, Ph.D. Elmsford, N.Y., Pergamon Press, 1973, 237 pp., no price listed.*

The Skyjacker, *revised ed., by David G. Hubbard, M.D. New York, Collier Books (Macmillan Co.), 1973, 317 pp., $1.95 (paper).*

The Organization and Delivery of Mental Health Services in the Ghetto: The Lincoln Hospital Experience, *by Seymour R. Kaplan and Melvin Roman. New York, Praeger Publishers, 1973, 306 pp., $19.50.*

Depressive Illness: Diagnosis, Assessment, Treatment, *edited by P. Kielholz. Baltimore, Williams & Wilkins Co. (U.S. agents), 1972, 281 pp., $17.75.*

Medical Student: Doctor in the Making, *by James A. Knight, M.D. New York, Appleton-Century-Crofts (Meredith Corp.), 1973, 235 pp., $7.95 (paper).*

The Control of Aggression: Implications from Basic Research, *edited by John F. Knutson. Chicago, Aldine Publishing Co., 1973, 287 pp., $12.50.*

Crisis Intervention and Counseling by Telephone, *edited by David Lester, Ph.D., and Gene W. Brockopp, Ph.D. Springfield, Ill., Charles C Thomas, 1973, 322 pp., $11.95.*

Depression and the Body, *by Alexander Lowen, M.D. Baltimore, Penguin Books, 1973, 318 pp., $1.95 (paper).*

Theodore Schroeder, a Cold Enthusiast: A Bibliography, *compiled by Ralph E. McCoy. Carbondale, Ill., Southern Illinois University Press, 1973, 86 pp., $3 (paper).*

Phenomenological, Existential, and Humanistic Psychologies: A Historical Survey, *by Henryk Misiak, Ph.D., and Virginia Staudt Sexton, Ph.D. New York, Grune & Stratton, 1973, 151 pp., no price listed (paper).*

For Patient's Sake: A Book for All Personnel Who Care for the Aged, *by Mildred I. Moe, R.N., B.S. Minneapolis, Geriatric Care, 1972, 61 pp., $4.95 (paper).*

Hashish and Mental Illness, *by Jacques-Joseph Moreau, edited by Hélène Peters, Ph.D., and Gabriel G. Nahas, M.D., Ph.D., translated by Gordon J. Barnett, Ph.D. New York, Raven Press, 1973, 226 pp., $9.75 (paper).*

A Dignified Requiem for a Necrophiliac, *by Jerry Mumford. Jericho, N.Y., Exposition Press, 1973, 75 pp., $3.50.*

Alternatives to Institutional Care for Older Americans: Practice and Planning. A Conference Report, *edited by Eric Pfeiffer, M.D. Durham, N.C., Center for the Study of Aging and Human Development, Duke University, 1973, 197 pp., no price listed (paper).*

Eugenic Sterilization, *compiled and edited by Jonas Robitscher, J.D., M.D. Springfield, Ill., Charles C Thomas, 1973, 116 pp., $7.95.*

The Analytic Situation: How Patient and Therapist Communicate, *edited by Hendrik M. Ruitenbeek, Ph.D. Chicago, Aldine Publishing Co., 1973, 215 pp., $8.50.*

Male and Female Homosexuality: A Comprehensive Investigation, *by Marcel T. Saghir, M.D., and Eli Robins, M.D. Baltimore, Williams & Wilkins Co., 1973, 335 pp., $11.95.*

Deaths of Man, *by Edwin S. Shneidman, Ph.D. New York, Quadrangle/New York Times Book Co., 1973, 232 pp., $8.95.*

The Psychoanalytic Theory of Defensive Processes, *by Hans Sjöbäck. New York, Halsted Press (John Wiley & Sons), 1973, 297 pp., $9.50.*

A General Guide to Abortion, *by R. Bruce Sloane, M.D., and Diana Frank Horvitz. Chicago, Nelson-Hall Co., 1973, 254 pp., $8.95.*

Drugs, Demons, Doctors, and Disease, *by Perry A. Sperber, M.D. St. Louis, Warren H. Green, 1973, 294 pp., $15.50.*

Task Force Report 5: Behavior Therapy in Psychiatry. *Washington, D.C., American Psychiatric Association, 1973, 64 pp., $3.50 (paper).*

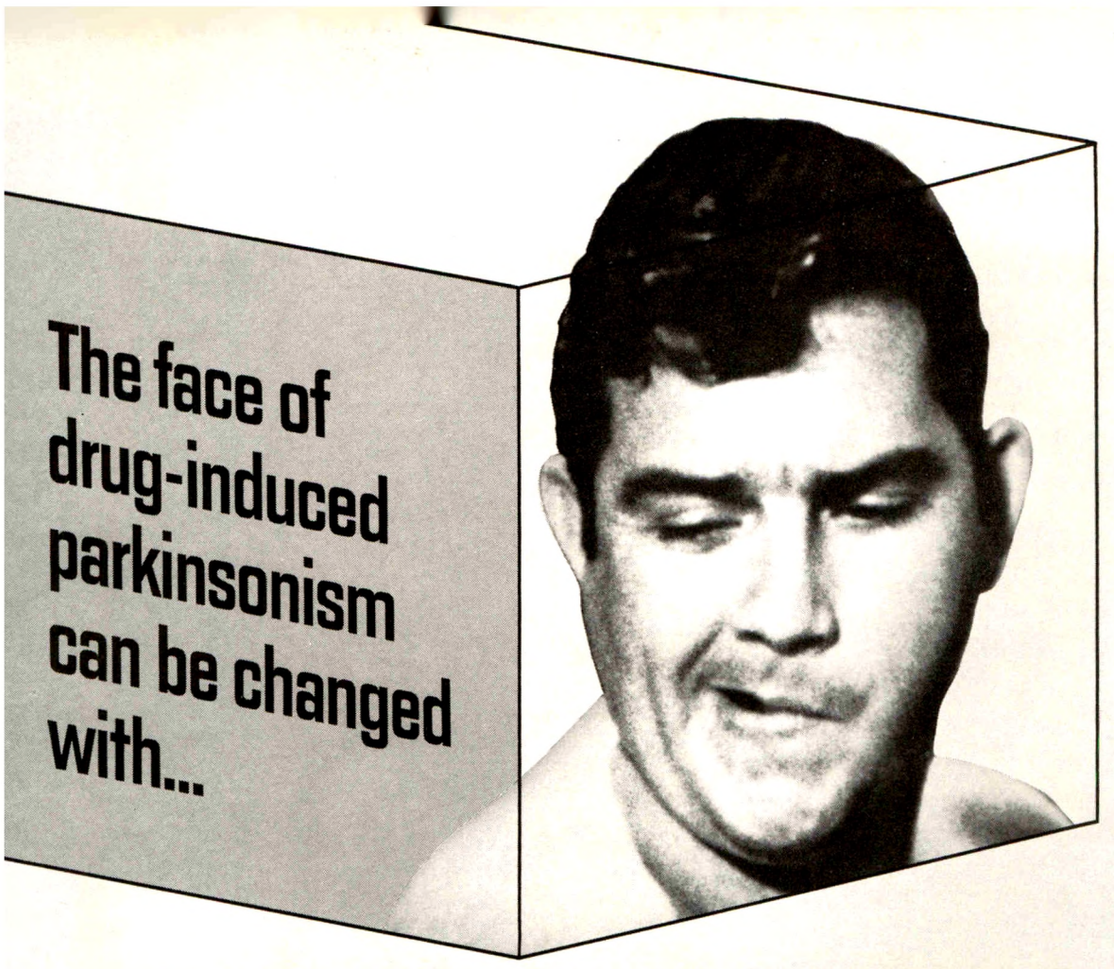
Task Force Report 7: Megavitamin and Orthomolecular Therapy in Psychiatry. *Washington, D.C., American Psychiatric Association, 1973, 48 pp., $3 (paper).*

Cholesterol Counter, *by Elizabeth S. Weiss and Rita Parsont Wolfson. New York, Pyramid Books, 1973, 61 pp., $1 (paper).*

Psychopharmacology in Medical Practice, *by David Wheatley, M.D. New York, Appleton-Century-Crofts (Meredith Corp.), 1973, 200 pp., $12.50.*

Youth and Drugs, *by the World Health Organization. WHO Technical Report Series No. 516. Washington, D.C., American Public Health Association, 1973, 45 pp., $1 (paper).*

Uprooting and After..., *by Charles Zwingmann and Maria Pfister-Ammende. New York, Springer-Verlag, 1973, 328 pp., $22.50.*



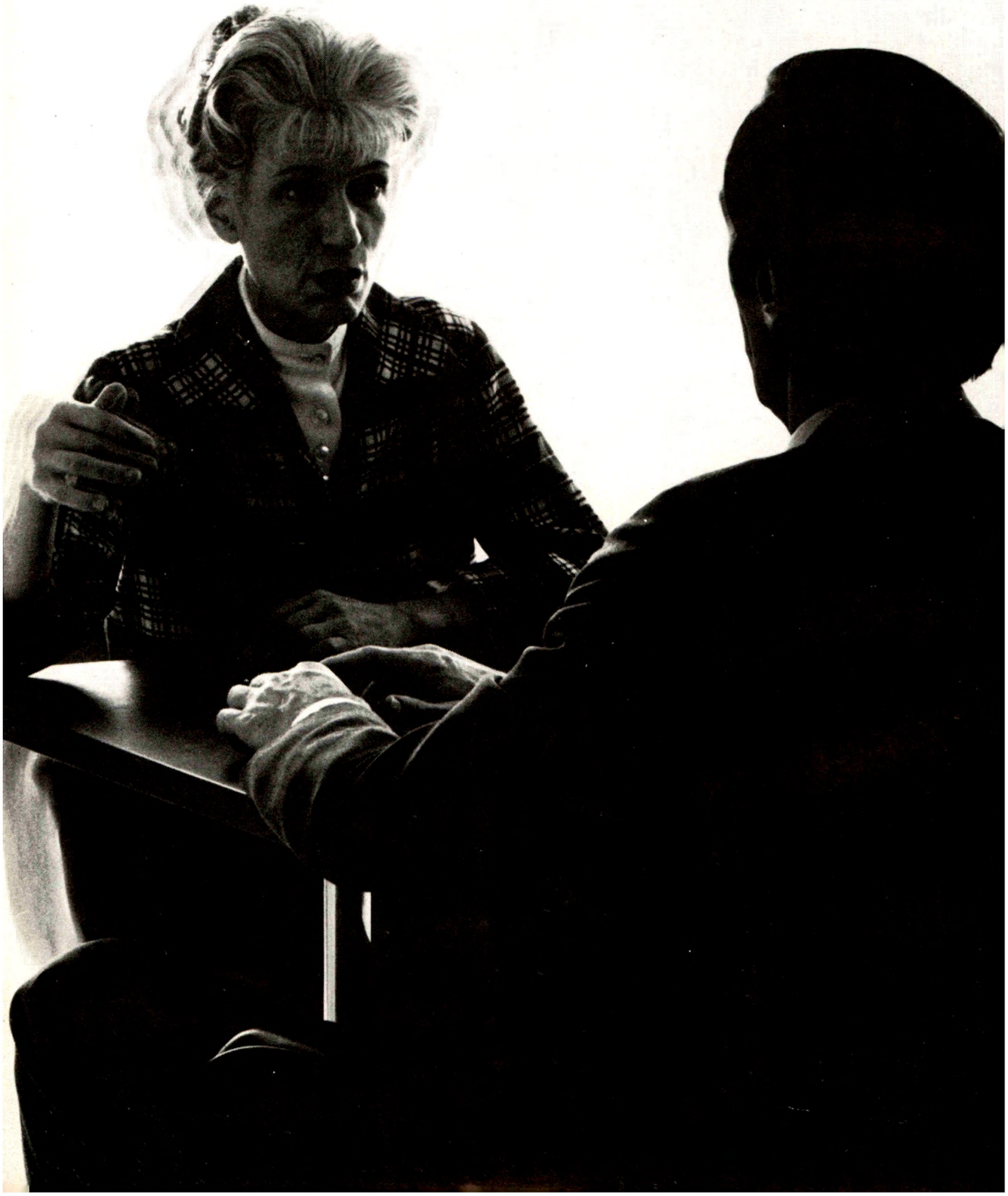
AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally; **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA

patients most in need of phenothiazines are often least able to cope with their side effects



TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®
(Benztropine Mesylate | MSD)
added to the regimen helps alleviate phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14:*246, May 1972.

Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia or hypotension and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Benztropine Mesylate, MSD) if they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000. Injection, containing 1.0 mg benztropine mesylate and 9.0 mg sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Extrapyramidal symptoms that develop slowly usually are less responsive. They may require more prolonged treatment with 2 to 6 mg a day.

For more detailed information, see full prescribing information.

from USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows...maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS



Withdrawn and uncommunicative?...Or responsive?

While psychotic symptoms remain ıcute, the barrier between you and the withdrawn, uncommunicative patient may ɔe insurmountable. Prompt intervention with HALDOL (haloperidol) ɔften makes it possible for you to reach... ·elate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

responsiveness often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

Haldol®
(HALOPERIDOL)
a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: HALDOL (haloperidol) is indicated for use in the management of manifestations of psychotic disorders.

It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy:*** Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children: Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General: Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Persistent Tardive Dyskinesia*—Tardive dyskinesia may appear during long term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 6/73

McNEIL McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

Announcing . . .

CONFERENCE ON SEVERE PSYCHOPATHOLOGIES IN CHILDHOOD

Sponsors: *Journal of Autism and Childhood Schizophrenia*, Division of Child and Adolescent Psychiatry of the Department of Psychiatry of the NYU–Bellevue Medical Center, and the National Institute of Mental Health.

Friday & Saturday – December 7-8, 1973

Alumni Auditorium
New York University School of Medicine
New York, N.Y. 10016

Program chaired by **Stella Chess**, M.D., Professor of Child Psychiatry, NYU School of Medicine, and **Theodore Shapiro**, M.D., Director of Child and Adolescent Psychiatry, NYU School of Medicine.

Program

Friday, December 7, 1973, 2-5 P.M.

I. Biological and Neurodevelopmental Factors in Childhood Schizophrenia and Early Infantile Autism

Chairman:
Magda Campbell, M.D., Assoc. Prof., NYU

1. New Biochemical Approaches to Psychopathologies of Childhood. **Mary Coleman**, M.D., Director, Children's Brain Research Clinic, Washington, D.C.
2. Intersensory Organization in Schizophrenic Children. **Margaret Hertzig**, M.D., Deputy Director, Rockland Children's Psychiatric Hospital and Adjunct Assoc. Prof., NYU, and **Harry Walker**, Ph.D.
3. Computerized Electroencephalogram and Evoked Potential in Childhood Psychosis. **Jovan Simeon**, M.D., Assoc. Prof., University of Missouri

Open General Discussion

Saturday, December 8, 1973, 9-11:30 A.M.

II. Clinical Research and Assessment of Severe Psychopathologies in Childhood

Chairman:
Peter Neubauer, M.D., Director, Child Development Center, Jewish Board of Guardians

1. Social and Verbal Interaction of Families of Schizophrenic Children. **William Goldfarb**, M.D., Ph.D., Director of Henry Ittleson Center, Clinical Prof. of Psychiatry, College of Physicians & Surgeons, Columbia University
2. Clinical Differentiation Among Children with Initial Language Complaints. **Stella Chess**, M.D., Prof. Child Psychiatry, NYU, and **Margarite Rosenberg**, M.S.W.
3. Language Development and Hierarchic Integration in a Psychotic Boy. **Theodore Shapiro**, M.D., Assoc. Prof. Psychiatry, **Hans Frieder Huebner**, M.D., Instructor, and **Magda Campbell**, M.D., Assoc. Prof. Psychiatry

Open General Discussion

Saturday, December 8, 1973, 1-5 P.M.

The Families of Schizophrenic Children
Lauretta Bender, M.D., Attending Psychiatrist, NY Psychiat. Institute, Clinical Prof., Columbia University (Retired)

Linguistic and Educational Factors in Severe Psychopathology in Childhood

Chairman:
Archie A. Silver, M.D., Clinical Prof., NYU Medical Center

1. An Experimental 9-Word Language: Mastery and Failure in Austic Children. **Don W. Churchill**, M.D., Assist. Director, Clinical Research Center, LaRue D. Carter Memorial Hospital, Ind.
2. On the Expansion of Language Space: From the Autistic to the Interpersonal. **Rudolph Ekstein**, Ph.D., Director, Childhood Psychosis Project, Reiss-Davis Child Study Center, and **Elaine Caruth**, Ph.D.
3. Special Education as the Basic Therapeutic Tool in Treatment of Severely Disturbed Children. **Carl Fenichel**, Ed.D., Director, League School

Open General Discussion

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

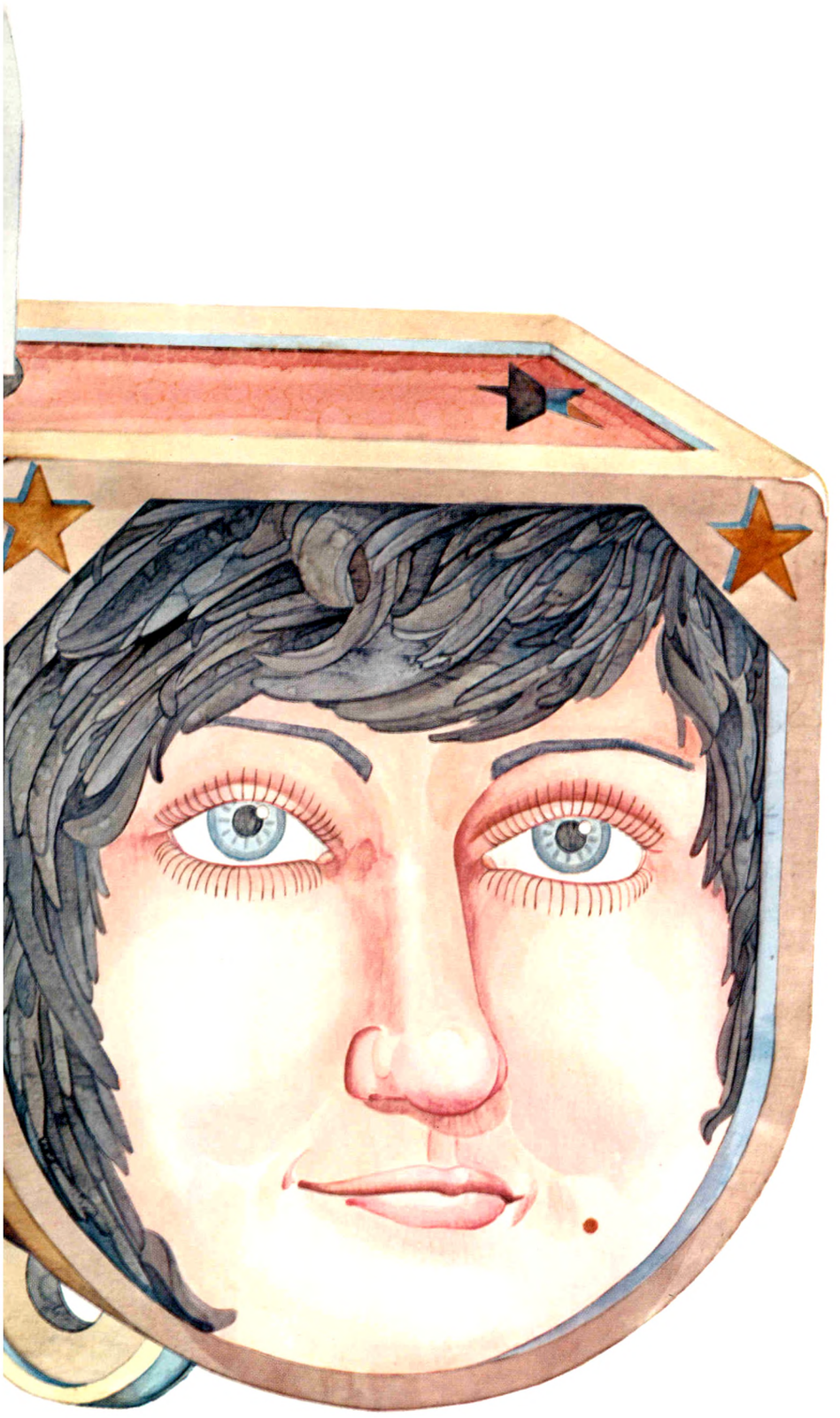
As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

In severe anxiety

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa. 19101

Please see important information on page after next.



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laborat
Philadelphia, P

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

Summit, N. J. 07901 (201) 277-0143

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director

OSCAR ROZETT, M.D., Medical Administrator

GRANVILLE L. JONES, M.D., Director of Research

DONALD H. GENT, M.D., Chief, Adolescent Program

MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator

Five Lives at Harvard

Personality Change During College

Stanley H. King

The case histories of five Harvard students, representative of a longitudinal research project involving 500 students, here brilliantly illuminate Stanley King's theory of adolescent development.

King believes that while the form of developmental issues may change, the underlying psychological processes of growth remain essentially the same.

As proof, he offers the psychological case histories of these students who grew up during one of the most crisis-laden periods of our recent past—the sixties. King is Lecturer in Clinical Psychology at Harvard. **$7.95**

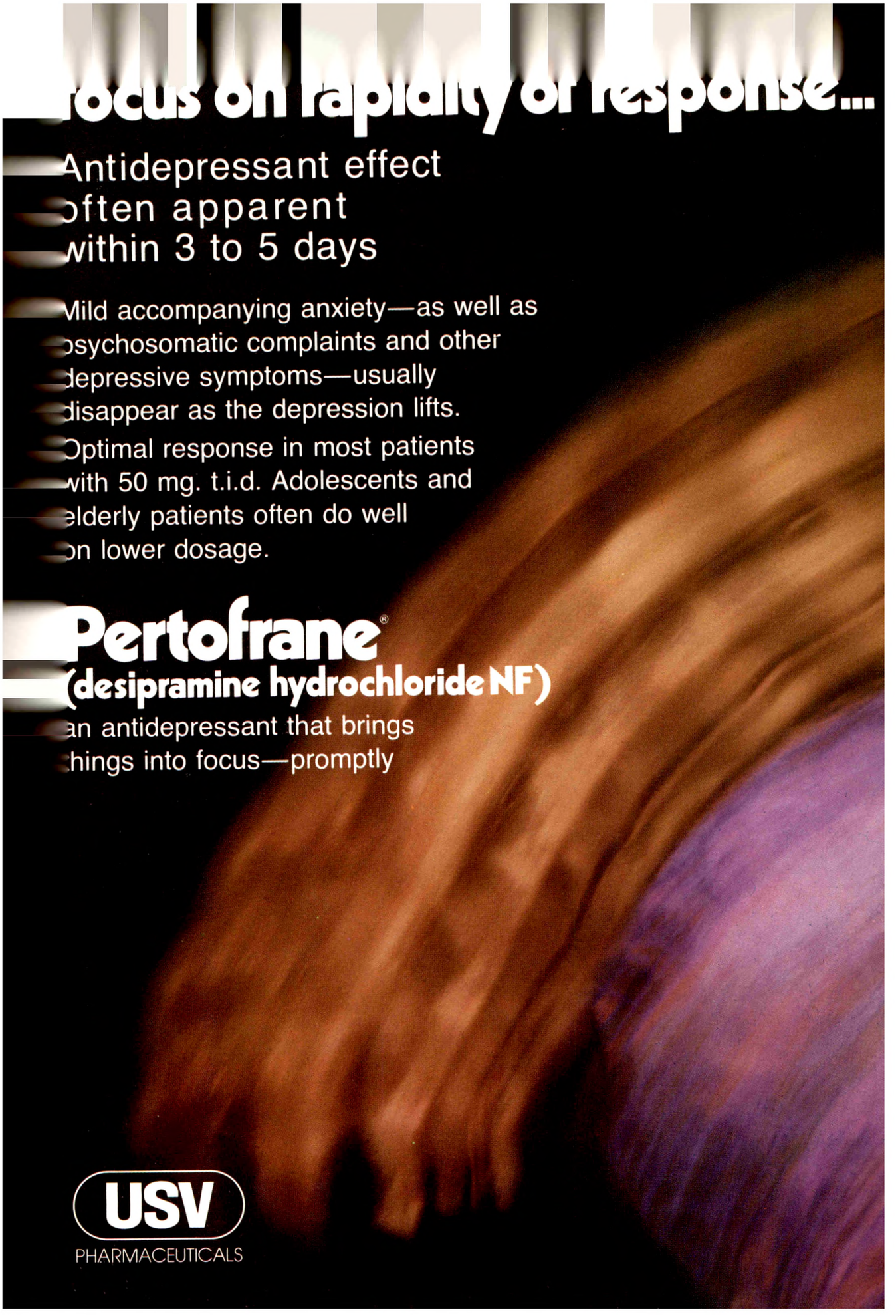
Mental Illness and the Economy

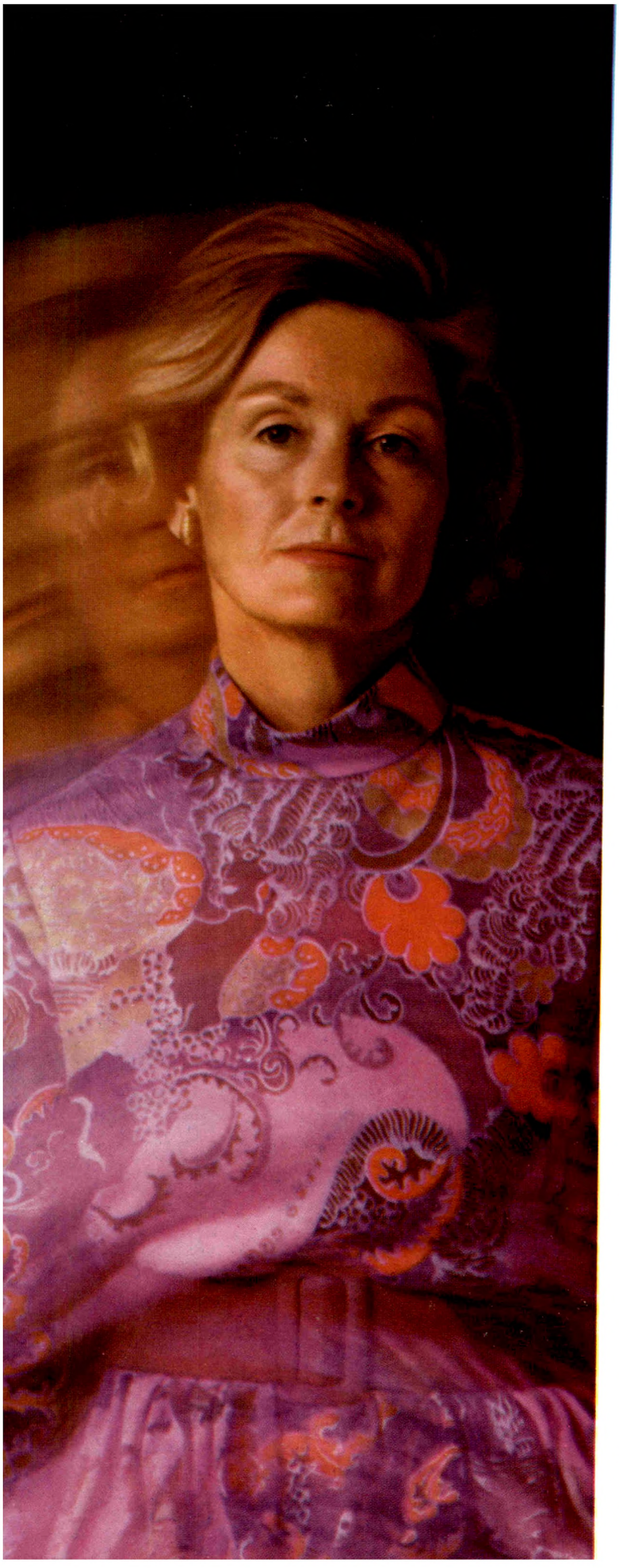
M. Harvey Brenner
Foreword by August B. Hollingshead

Mental hospital admissions rise when the economy falls. This is Dr. M. Harvey Brenner's deceptively simple formula. A formula that has far-reaching psychiatric, sociological and theoretical implications. Brenner, Associate Professor in the School of Hygiene and Public Health at Johns Hopkins University, proves the theory with data covering more than 127 years.

Dr. August B. Hollingshead of Yale University calls Brenner's discovery "a milestone in the development of our knowledge regarding the functioning of the economy and the use of mental hospitals." **$15.00**

HARVARD UNIVERSITY PRESS
Cambridge, Mass. 02138

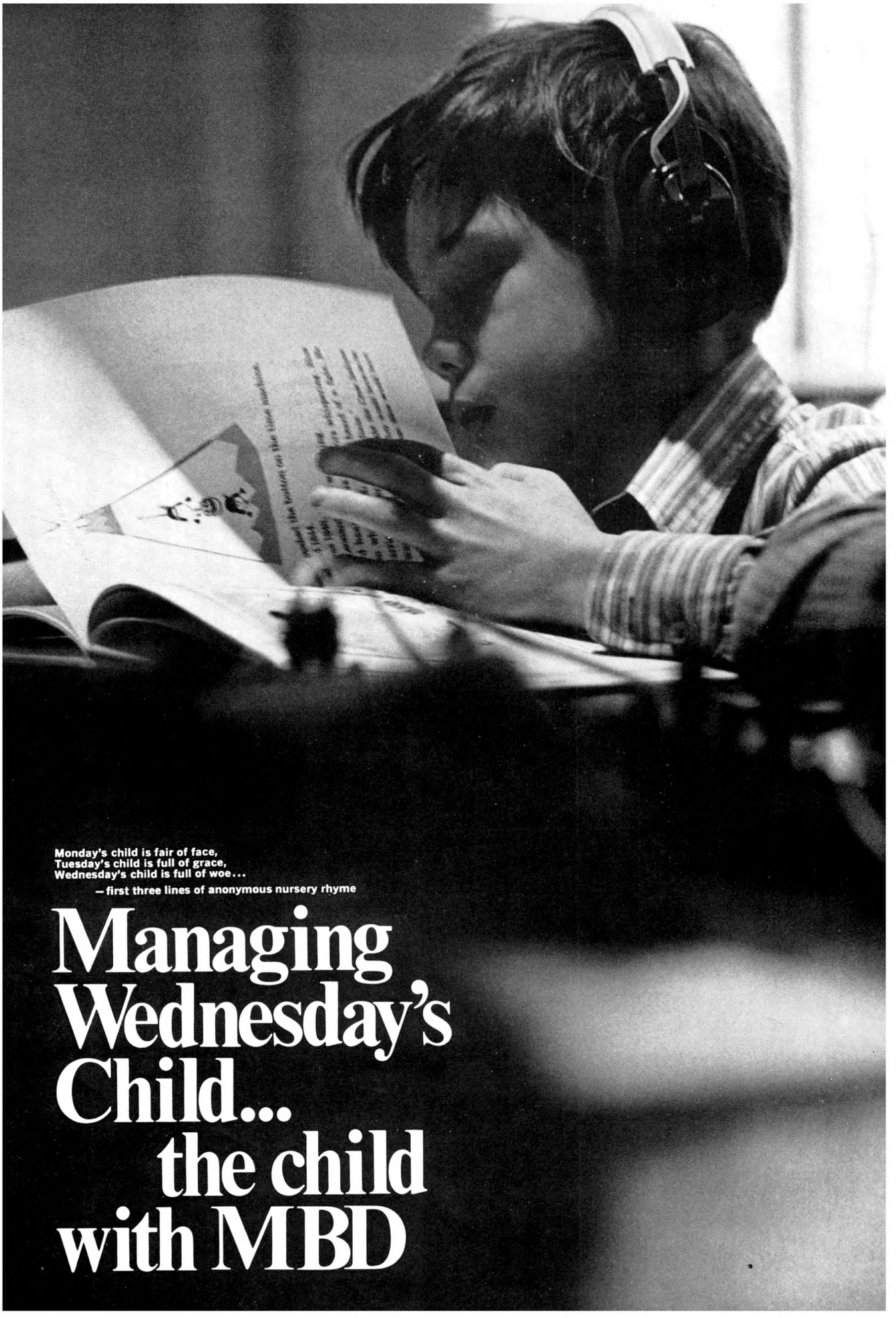

ocus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS



Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...
—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD – Minimal Brain Dysfunction – can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference

1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)
TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established.

Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.

Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary.

Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (*eg*, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

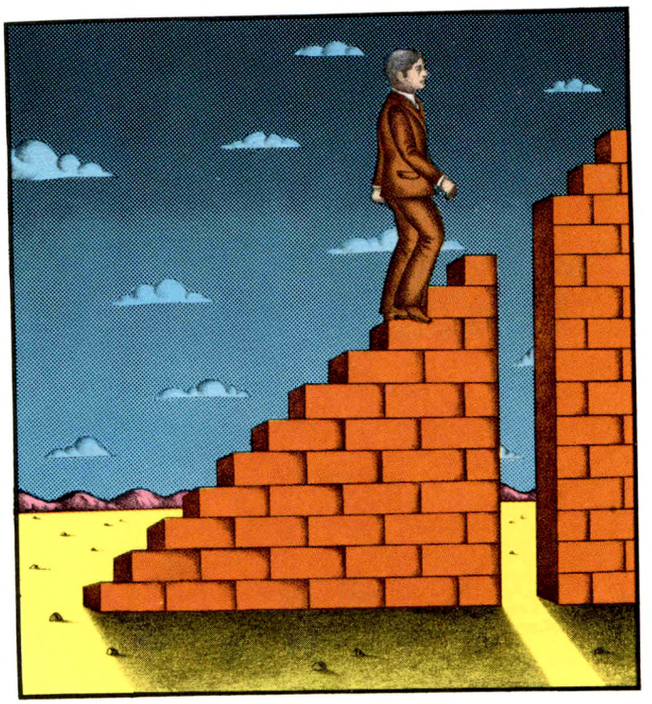
2/4754 17

Ritalin®
(methylphenidate)
only when medication is indicated

CIBA

The psychoneurotic patient's prognosis may be good...

As a group, psychoneurotic patients tend to respond positively to psychotherapy. Follow-up studies indicate that up to two-thirds of treated patients may show significant and often sustained improvement.



In individual cases, the prognosis appears particularly favorable for the psychoneurotic who has had a good premorbid personality structure and a record of reasonably good interpersonal competence. As might be expected, patients judged to be "attractive" candidates for therapy often tend to derive greater benefits from therapeutic intervention than those considered "unattractive."

The global assessment of "attractiveness" is influenced by such factors as youthfulness, intelligence, ability to relate and good occupational history.

But excessive anxiety can block recovery...

Anxiety is the hallmark of psychoneurotic states. In excess it may not alter the patient's "prognostic rating," but it can slow therapeutic progress—sometimes to a marked extent. At the outset of therapy, for instance, severe or persistent anxiety can be particularly

obstructive, sometimes hampering for long periods the patient's ability to participate in a productive psychotherapeutic relationship. At later stages, intense anxiety may impair the patient's receptivity to further probing and block his attempts to retrieve and express pertinent material.

When the patient's disabling anxiety continues to impede therapeutic progress, management of his condition may often be significantly facilitated by adjunctive Librium (chlordiazepoxide HCl).

Librium generally relieves excessive anxiety without unduly impairing mental acuity or ability to perform. As with all CNS-acting drugs, however, patients should be cautioned against hazardous occupations requiring complete mental alertness. (See Warnings section in summary of prescribing information.) When the patient's anxiety has been reduced to appropriate levels, Librium should, of course, be discontinued.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

To relieve obstructive anxiety consider Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules
Up to 100 mg daily for severe anxiety

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models– **PORTABLE FOR OFFICE AND CLINIC**



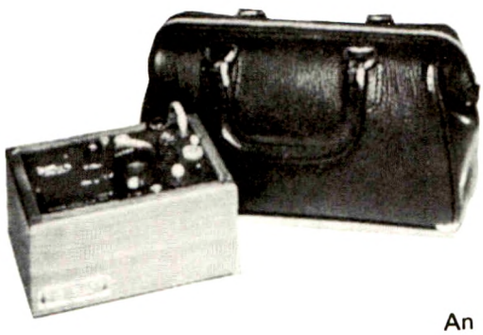
The Reiter MODEL SOS–THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives–patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes –a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211

CHILD PSYCHIATRY FELLOWSHIPS

New, Board Approved, Child Psychiatry Fellowships offered in an innovative, established clinical program. Outpatient, Community Child Psychiatry and Residential Treatment offer opportunities for a variety of treatment techniques. Crisis intervention ("life-space" interviews); behavioral therapy, pharmacotherapy; individual, group and family treatment methods; dynamic, social and developmental psychiatry taught. Learning by independent study, seminars, supervised experiences. Administrative experiences and training may be arranged. Multi-disciplinary staff including; six child psychiatrists, pediatrician, pediatric neurologist, psychologist, social workers, special education teachers, speech therapist, occupational therapists, recreational therapists and other consultants.

Program affiliated with the University of Michigan and a variety of clinical settings including; community mental health centers, child guidance clinics, etc. Salaries negotiable. Contact: William E. Kirk, M.D., Director, York Woods Center, Box A2, Ypsilanti, Michigan 48197. Phone: (313) 434-3400.

AN EQUAL OPPORTUNITY EMPLOYER

CHAIRMAN & PROFESSOR OF PSYCHIATRY

Department of Psychiatry, University of Pennsylvania. In compliance with University policy, qualified candidates are invited to submit their credentials to: Office of the Dean, University of Pennsylvania, School of Medicine, 36th & Hamilton Walk, Philadelphia, Pa. 19104, Att: Chairman Psychiatry Search Committee.



THE AMERICAN JOURNAL OF PSYCHIATRY

NOW, your journals can become an attractive permanent part of your professional library. These famous Jesse Jones volume files, especially designed to keep your copies orderly, readily accessible for future reference—guard against soiling, tearing, wear or misplacement of copies. These durable files will support 150 lbs. Looks and feels like leather and is washable. The 23-carat gold lettering makes it a fit companion for the most costly binding.

Reasonably priced, too. Only $4.25, 3 for $12.00, 6 for $22.00 POSTPAID U. S. A. ORDERS ONLY. Satisfaction unconditionally guaranteed or your money back.

JESSE JONES BOX CORP. (Since 1843)
Department JP9—Philadelphia 41, Pa. 19141

New from Yale

The Psychoanalytic Study of the Child

Volume twenty-eight

edited by Ruth Eissler, Anna Freud, Marianne Kris, and Albert J. Solnit

It is with enormous pride that Yale University Press assumes publication of Volume 28 of the *Psychoanalytic Study of the Child*. The distinguished annual contains outstanding original papers in psychoanalytic theory and practice. It brings together findings from all areas of analytic research and offers a rich mixture of clinical and theoretical material.

"Each year there are just a few volumes that achieve eminence and represent a unique contribution. This volume is in such a category. Not only does this text stimulate and enlighten the reader, but it is a serendipitous experience in personality development." *Archives of Internal Medicine* Volumes 26 and 27 are also available and standing orders are welcome.

$15.00

Yale University Press
New Haven and London

ELAVIL®
(AMITRIPTYLINE HCl|MSD)
useful in many therapeutic settings

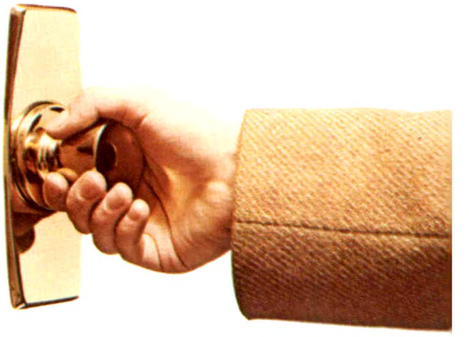


In the psychiatrist's office. Whatever other therapeutic facilities have been developed, the psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations

In the general hospital. The general hospital today usually provides a psychiatric unit where depressed patients may be treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic. With follow-up treatment often necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital. Here where severely depressed patients present challenges for psychiatrist and staff alike, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



In the community mental health center. A remarkable innovation in the field of modern psychiatry, this center offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

ELAVIL should not be used during the acute recovery phase following myocardial infarction, in patients hypersensitive to it or in those who have received an MAOI within two weeks. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Concurrent electroshock therapy may increase hazards associated with such therapy. Patients with cardiovascular disorders should be watched closely. The drug may impair mental or physical abilities required in hazardous tasks and may potentiate the effects of alcohol.

In many therapeutic settings—one proven antidepressant

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME

addendum

ELAVIL

(AMITRIPTYLINE HCl | MSD)

dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for most outpatients, who generally do well on 25 mg three times a day. This dosage may be increased to a total of 150 mg a day. Dosage increases are made preferably in the late afternoon or at bedtime. The sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be indicated whenever higher dosages are required, as for example when increases are necessary in the late afternoon or bedtime doses. It may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher dosages.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

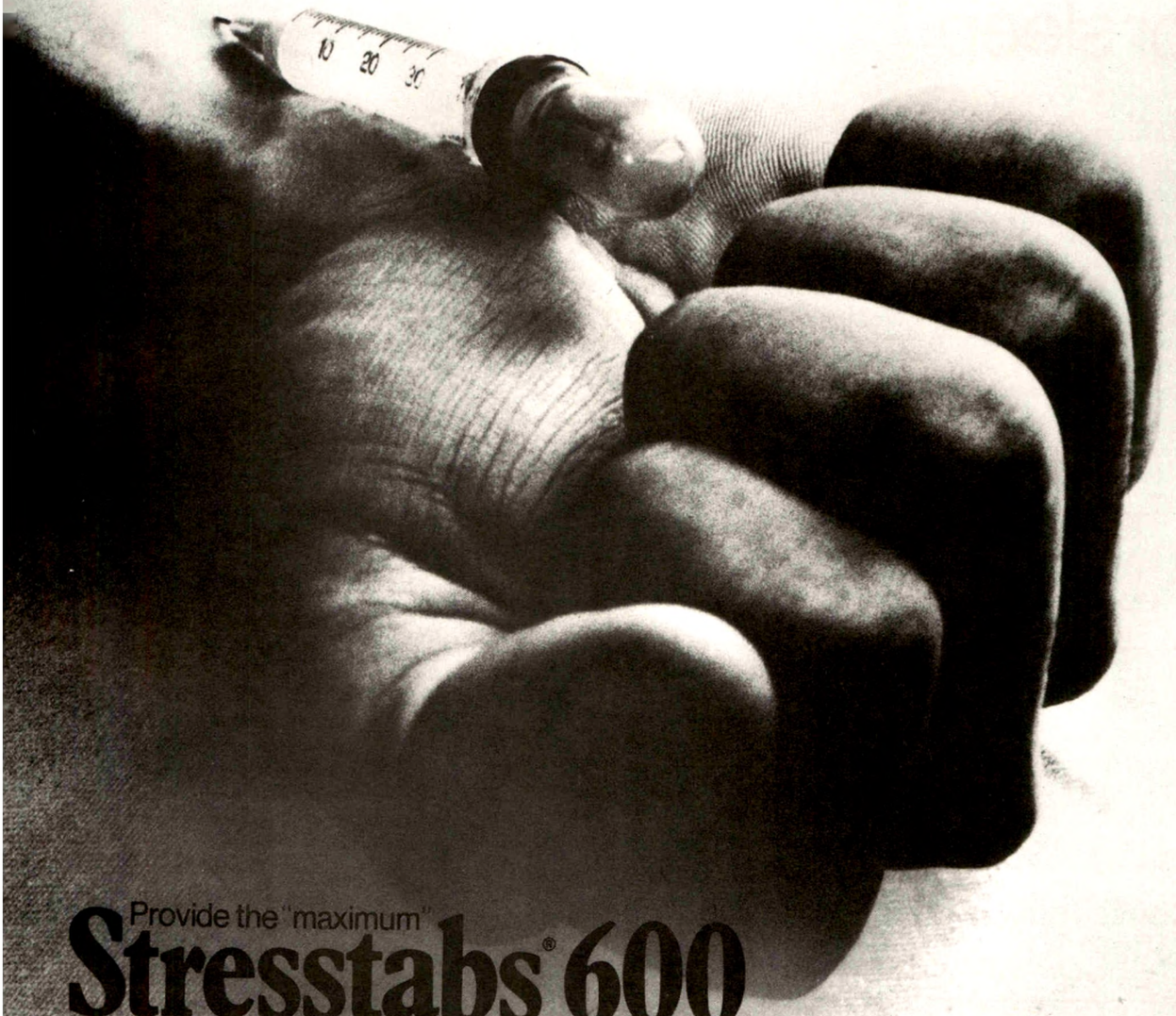
For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

in the treatment of clinically significant depression

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

High Potency Stress Formula Vitamins

Each Tablet Contains:

Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3

For the psychiatrist

The documented properties of DALMANE® (flurazepam HCl) for sleep

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.

The properties of Dalmane have been carefully defined and thoroughly evaluated. Results of these investigations—many of which are cited here—have documented the effectiveness and relative safety of Dalmane when the etiology of insomnia indicates need for sleep medication.

Prompt sleep induction, effective through the night[1-13]

Consistently effective night after night[2,3,5,6,8-13]

Relative safety[11,14,15*]

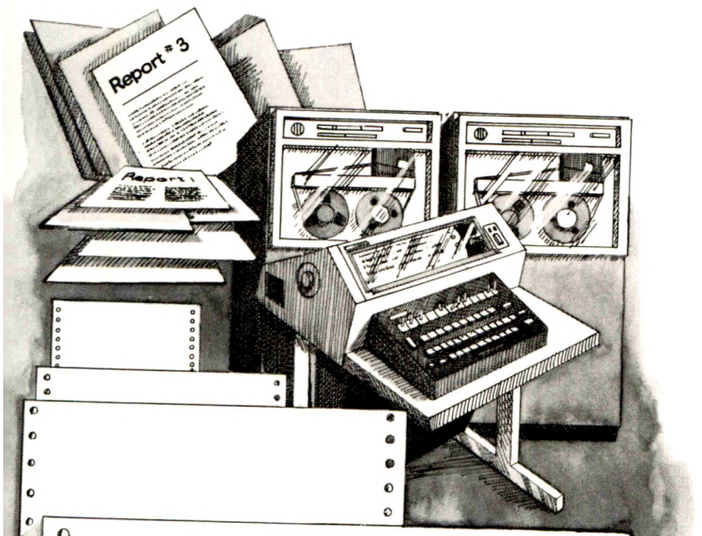
Usefulness in chronically anticoagulated patients[11]

1. Kales, A.: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Philadelphia, Lippincott, 1969, p. 331. **2.** Kales, J., *et al.: Clin. Pharmacol. Ther., 12*:691, 1971. **3.** Jacobson, A., *et al.: Psychophysiology, 7*:345, 1970. **4.** Kales, A., and Kales, J.: *J.A.M.A., 213*:2229, 1970. **5.** Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970; and at 42nd Annual Scientific Meeting, Aerospace Med. Assoc., Houston, April 26-29, 1971. **6.** Karacan, I., *et al.:* "The Sleep Laboratory in the Investigation of Sleep and Sleep Disturbances," Scientific Exhibit presented at Amer. Psychiat. Assoc., Washington, D.C., May 3-7, 1971. **7.** Hartmann, E.: *Psychopharmacologia (Berl.), 12*:346, 1968. **8.** Dement, W. C.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **9.** Vogel, G. W.: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **10.** Kales, A., and Kales, J. D.: *Pharmacol. Physicians, 4*:1, 1970. **11.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. **12.** Kales, A., *et al.: Arch. Gen. Psychiat., 23*:226, 1970. **13.** Meyer, J. A.: "Flurazepam Hydrochloride for the Short-Term Treatment of Insomnia in the

*Generally, when adverse effects were reported clinically with Dalmane (flurazepam HCl), they were mild and infrequent. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most often, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

Little "hang-over" effect on awakening[11,14]

Hospitalized Post-Surgical Patient," Scientific Exhibit presented at AAGP, San Francisco, Calif., Sept. 28-Oct. 1, 1970. **14.** Zimmerman, A. M.: *Curr. Ther. Res., 13*:18, 1971. **15.** Greenblatt, D., and Shader, R.: *Ann. Intern. Med., 77*:91, 1972.



Data about Dalmane (flurazepam HCl) on request

The references cited constitute only a part of the Dalmane bibliography. Additional data are available through the Roche Professional Services Department. Augmenting this service is RETRIEVE, a computer-operated data retrieval system which screens data from the published English language papers on Dalmane to help provide rapid answers to your specific questions. Coded into the computerized index are parameters that include patient age, sex, condition; product dose, side effect, frequency of administration; other medications or therapy; length, type and size of study, and pharmacology.

For specific answers to any questions you might have about Dalmane, write or call: Roche Professional Services Department, Roche Laboratories, Nutley, N.J. 07110. Telephone: (201) 235-2355.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

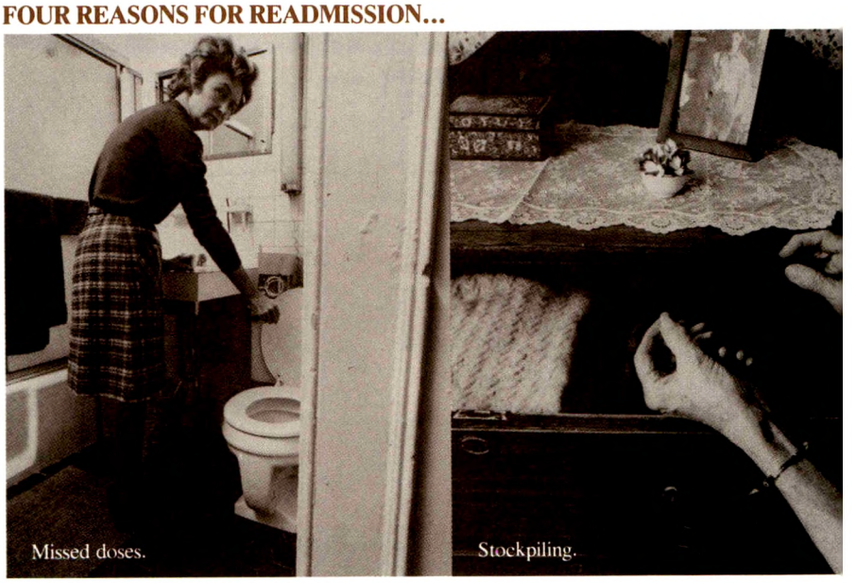
DALMANE®
(flurazepam HCl)
When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

FOUR REASONS FOR READMISSION...



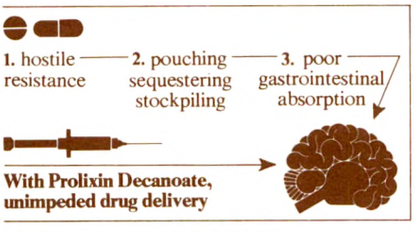
For schizophrenic patients...

A way out

that helps them stay out

Controlled Drug Delivery with
PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)
Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer, with an average duration of effect of about 2 weeks

Controlled drug delivery helps prevent disruption of therapy—one of the commonest causes of psychotic relapse. For the inpatient it means unimpeded drug delivery with improved chances of discharge.



For the outpatient it means improv chances for prolonged remission: "...t duration of remission and the inciden of relapse are directly related to keepi the patient medicated after his return the community."[1]

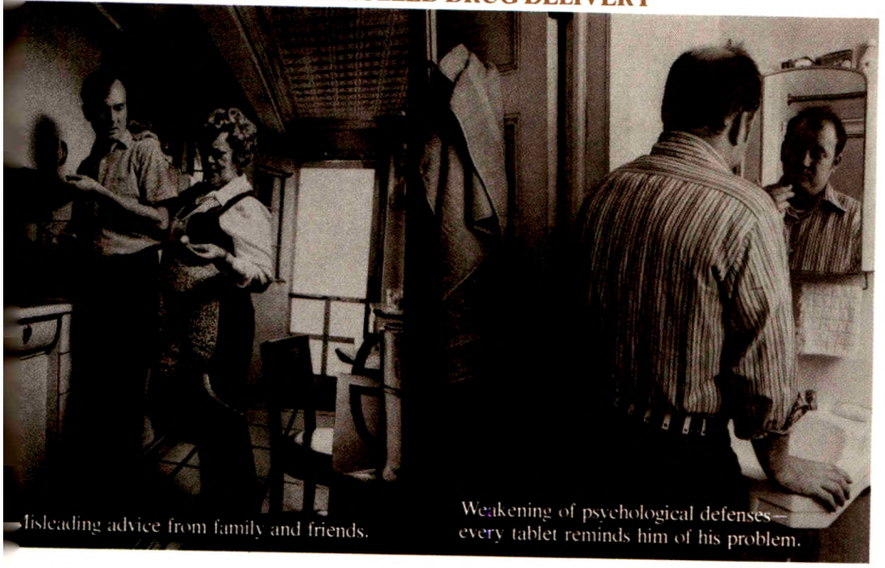
Controlled drug delivery helps the inpatient out

- Keeps the patient medicated...he make him more manageable, more cc fortable, and more amenable to to treatment. With oral medication, on t other hand, approximately one out every five patients does not take his m ication, even when administered by t nursing staff.[2]
- Eliminates the problem of missed, l or hidden doses. Prevents stockpiling
- Assures regular medication intake.
- Lightens responsibilities of the hosp staff...simplifies patient management obviating the need for multiple doses.
- Increases the likelihood of dischar In one study[3] of 24 long-term hosp patients treated with Prolixin Decano (Fluphenazine Decanoate Inj tion) every 7 days to 3 weeks:

DISCHARGED	CONSIDERED DISCHARGEABLE	NO IMPROVEME
13	4	7

Dischargeability "may also have been hanced because the staff, the pati and the family were assured of an equate and regular medication intake

GOOD REASONS FOR CONTROLLED DRUG DELIVERY



Misleading advice from family and friends.

Weakening of psychological defenses—every tablet reminds him of his problem.

Controlled drug delivery helps keep the outpatient out

- Helps assure continuity of medication ..makes prolonged remission more likely. With oral medication, on the other hand, "approximately 50% of all discharged psychotic patients fail to take even the first dose of their outpatient medication."[2]
- Enhances chances for rehabilitation... promotes acceptance socially, in the family, and on the job because of sustained control of symptomatology.
- Eases family adjustment by eliminating concern about "taking his medicine."
- Avoids the potential dangers of stockpiling, particularly for the suicidal.
- Once administered, therapy cannot be altered by the patient, by his family, or by anyone else.
- The unique advantages of controlled drug delivery apply equally to the patient who has never been hospitalized.

They are advantages that can help make custodial care unnecessary as long as treatment continues.

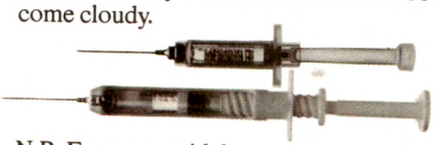
Controlled drug delivery saves time, reduces cost in the hospital, clinic, office

Saves time in the hospital:

18 PATIENTS	18 PATIENTS
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Saves time in the clinic and in the office: Most patients report for their injections only once in every two-week period.

Prolixin Decanoate (Fluphenazine Decanoate Injection) also offers the convenience of easy-to-use Unimatic® Syringes: Unimatic single-dose preassembled syringes and Unimatic cartridge-needle units with a reusable plastic holder. Vials of 5 cc. Prolixin Decanoate are available for use with dry syringes and needles (at least 21 gauge). Use of a wet needle may cause the solution to become cloudy.



N.B. Extrapyramidal reactions occur frequently. Most often they are reversible and can usually be controlled by administration of antiparkinsonian drugs. However, in some instances, they are persistent—particularly in the case of tardive dyskinesia (see Adverse Reactions section of Brief Summary). Patients should be forewarned and reassured.

References: 1. Kinross-Wright, V. J.: Cited in Med. Tribune, Sept. 13, 1965, pp. 1, 27. 2. Goldberg, H. L., DiMascio, A. and Chaudhary, B.: Psychosomatics 11:173, May-June 1970. 3. Keskiner, A. et al.: Arch. Gen. Psychiatry 18:477, Apr. 1968. 4. Platt, R.: Br. J. Social Psychiatry 2:187, 1968.

Controlled Drug Delivery *with* PROLIXIN® DECANOATE FLUPHENAZINE DECANOATE INJECTION)

For product Brief Summary, see following page.

SQUIBB HOSPITAL DIVISION

Controlled Drug Delivery

in schizophrenia with

PROLIXIN® DECANOATE

(FLUPHENAZINE DECANOATE INJECTION)

BRIEF SUMMARY

Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy. Safety and efficacy in children have not been established because of inadequate experience in use in children.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anticholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of antiparkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight change, peripheral edema, abnormal lactation, gynecomastia, menstrual irregularities, false results on pregnancy tests, impotency in men and increased libido in women have occurred in some patients on phenothiazine therapy.

Allergic Reactions—Itching, erythema, urticaria, seborrhea, photosensitivity, eczema and exfoliative dermatitis have been reported with phenothiazines. The possibility of anaphylactoid reactions should be borne in mind.

Hematologic—Blood dyscrasias including leukopenia, agranulocytosis, thrombocytopenic or nonthrombocytopenic purpura, eosinophilia, and pancytopenia have been observed with phenothiazines. If soreness of the mouth, gums or throat or any symptoms of upper respiratory infection occur and confirmatory leukocyte count indicates cellular depression, therapy should be discontinued and other appropriate measures instituted immediately.

Hepatic—Liver damage manifested by cholestatic jaundice, particularly during the first months of therapy, may occur; treatment should be discontinued. A cephalin flocculation increase, sometimes accompanied by alterations in other liver function tests, has been reported in patients who have had no clinical evidence of liver damage.

Others—Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

Systemic lupus erythematosus-like syndrome, hypotension severe enough to cause fatal cardiac arrest, altered electrocardiographic and electroencephalographic tracings, altered cerebrospinal fluid proteins, cerebral edema, asthma, laryngeal edema, and angioneurotic edema; with long-term use, skin pigmentation and lenticular and corneal opacities have occurred with phenothiazines. Local tissue reactions occur only rarely with injections of fluphenazine decanoate.

For full prescribing information, consult package insert.

HOW SUPPLIED: 1 cc. Unimatic® single dose preassembled syringes and cartridge needle units, and 5 cc. vials.



SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H423-023

Princeton, N. J. 08540

INDEX TO ADVERTISERS
November 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

AYERST
Antabuse A20–A21

CHARLES C THOMAS A13

CIBA PHARMACEUTICAL COMPANY
Ritalin A19–A20
Ritalin MBD A42–A43

DEVEREUX FOUNDATION C4

EMPLOYMENT OPPORTUNITIES A47

HARVARD UNIVERSITY PRESS A39

JOURNAL OF AUTISM AND CHILDHOOD SCHIZOPHRENIA A35

KNOLL PHARMACEUTICAL
Akineton A29

LAKESIDE LABORATORIES
Norpramin A58–C3

LEDERLE
Stresstabs A51
Artane A6-A7

McNEIL LABORATORIES, INC.
Haldol A33–A34

MERCK SHARP & DOHME
Cogentin A30–A31
Elavil A48–A50
Triavil A14–A17
Vivactil A24–A25

PENNWALT CORPORATION
Kolyum, Adapin A9–A12

REUBEN REITER, ScD. INC.
Electrostimulators A46

ROCHE LABORATORIES
Dalmane A52–A53
Librium A44–A45

SANDOZ
Mellaril A26–A28

SANITARIUMS AND PRIVATE HOSPITALS A8, A9

SMITH KLINE AND FRENCH LABORATORIES
Stelazine C2
Thorazine A22–A23

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A54–A56

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A32
Pertofrane A40–A41

WYETH LABORATORIES
Serax A36–A38

YALE UNIVERSITY PRESS A47

MOVING?

PLEASE NOTIFY US 6 WEEKS IN ADVANCE

Change of address or name for THE AMERICAN JOURNAL OF PSYCHIATRY and/or PSYCHIATRIC NEWS. Please use only one address for APA mailings. Thank you.

FORMER ADDRESS:

PASTE LABEL HERE

NEW ADDRESS OR NAME:
(The number of characters indicated include spaces.)

APA IDENTIFICATION NO. (6 characters)

NAME: (24 characters)

(last) (first) (middle initial)

STREET ADDRESS: line #1 (24 characters)

STREET ADDRESS: line #2 (24 characters)

CITY: (16 characters)

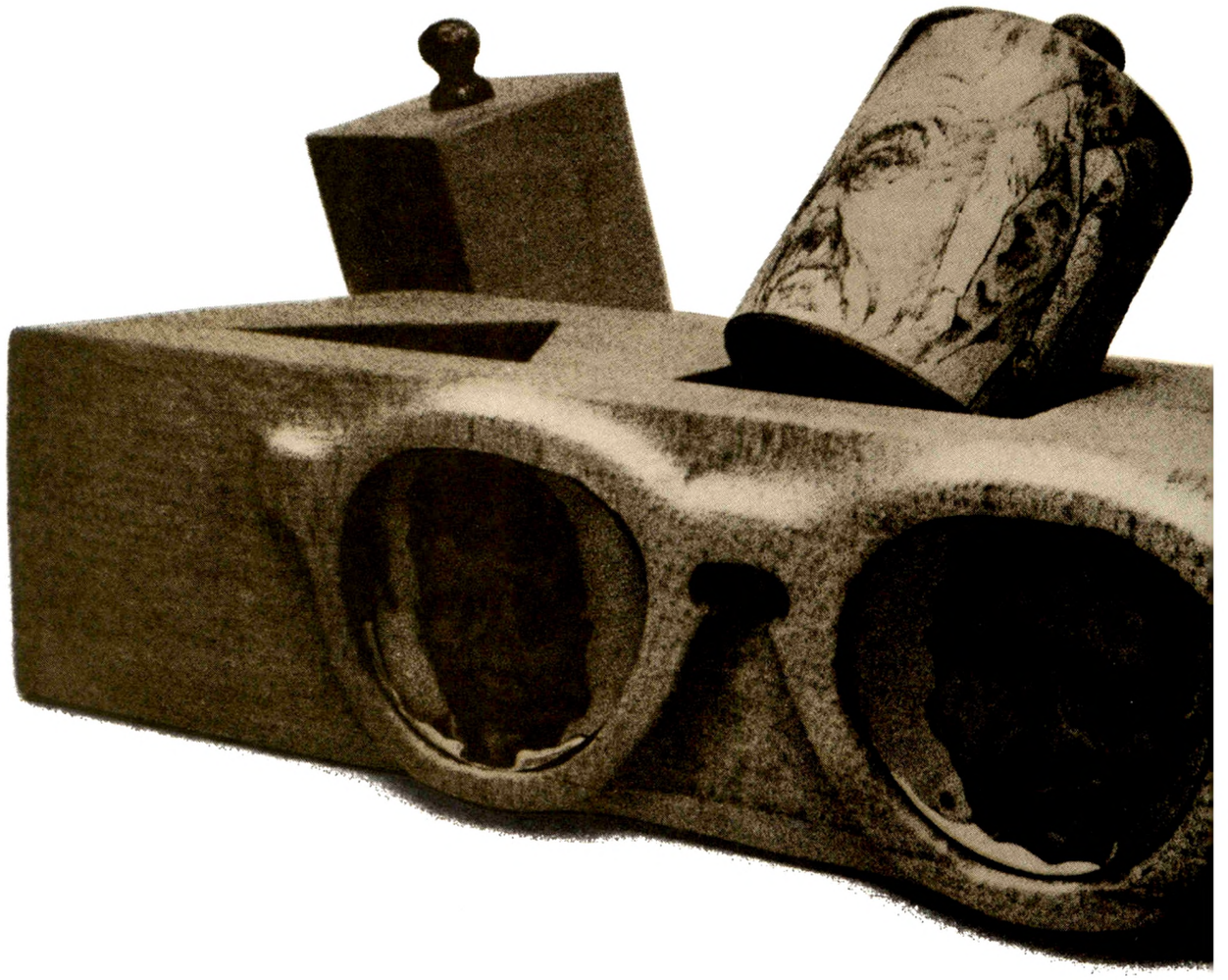
STATE: (2 characters)

ZIP: (7 characters)

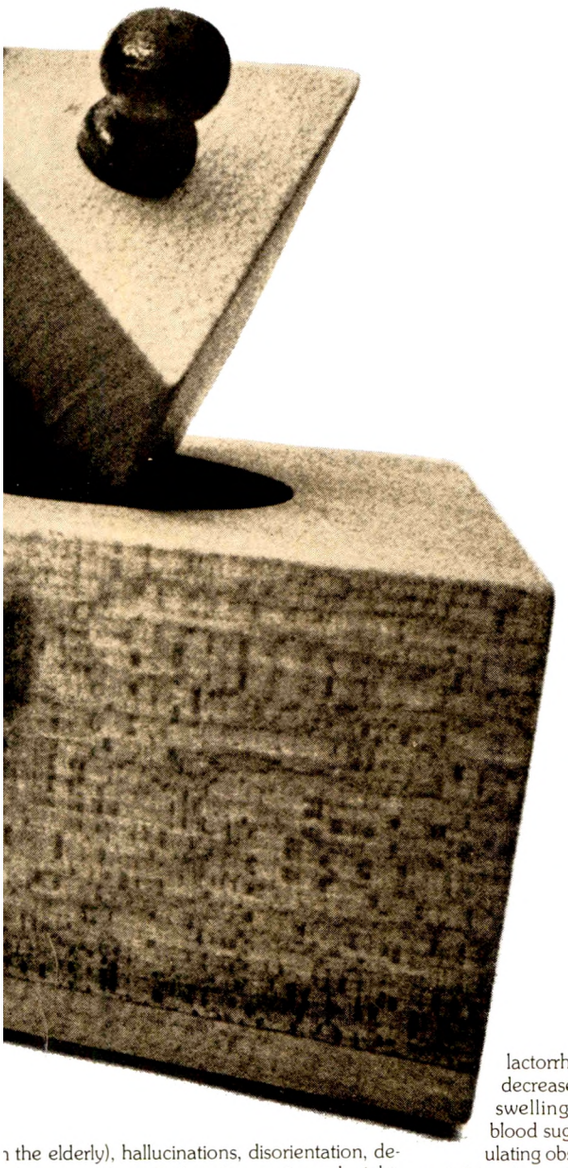
MAIL TO:

Division of Manpower Research and Development
AMERICAN PSYCHIATRIC ASSOCIATION
1700 Eighteenth St., N.W.
Washington, D. C. 20009

Help improv . youi depr ɔɔed patients' ability to cope.



In Brief:
Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.
Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.
Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.
Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.
Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosis i schizophrenic patients. Close supervision an careful adjustment of dosage are required whe this drug is given along with anticholinergic c sympathomimetic drugs. While taking this drug response to alcoholic beverages may be exagger ated. There is limited clinical experience in th concurrent administration of ECT and antide pressant drugs; thus, one should consider th possibility of increased risk relative to benefit Discontinue as soon as possible prior to electiv surgery because of possible cardiovascula effects. Hypertensive episodes have bee observed during surgery in patients on desipra mine hydrochloride. Leukocyte and differenti counts should be performed in any patient wh develops fever and sore throat during therap the drug should be discontinued if there is neu tropenia.
Adverse Reactions: *Cardiovascular:* hypoter sion, hypertension, tachycardia, palpitation arrhythmias, heart block, myocardial infarction stroke. *Psychiatric:* confusional states (especiall



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

n the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

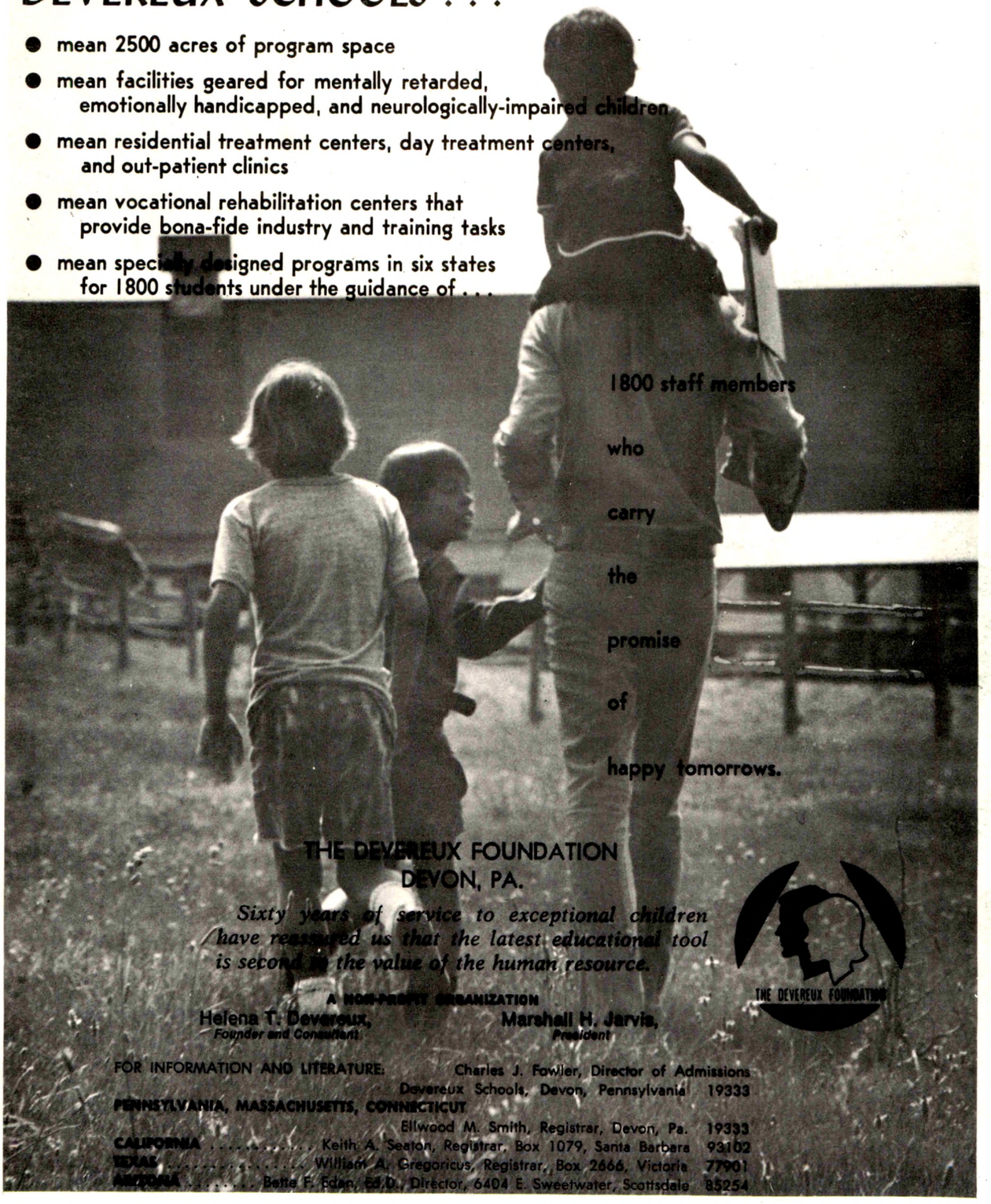
How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.*, sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.*, sugar coated tablets, light green, in bottles of 50, 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

DEVEREUX SCHOOLS . . .

- mean 2500 acres of program space
- mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impaired children
- mean residential treatment centers, day treatment centers, and out-patient clinics
- mean vocational rehabilitation centers that provide bona-fide industry and training tasks
- mean specially designed programs in six states for 1800 students under the guidance of . . .



1800 staff members who carry the promise of happy tomorrows.

THE DEVEREUX FOUNDATION
DEVON, PA.

Sixty years of service to exceptional children have reassured us that the latest educational tool is second to the value of the human resource.

A NON-PROFIT ORGANIZATION

Helena T. Devereux, *Founder and Consultant*

Marshall H. Jarvis, *President*

THE DEVEREUX FOUNDATION

FOR INFORMATION AND LITERATURE:

Charles J. Fowler, Director of Admissions
Devereux Schools, Devon, Pennsylvania 19333

PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT
Ellwood M. Smith, Registrar, Devon, Pa. 19333

CALIFORNIA . . . . . Keith A. Seaton, Registrar, Box 1079, Santa Barbara 93102

TEXAS . . . . . William A. Gregoricus, Registrar, Box 2666, Victoria 77901

ARIZONA . . . . . Bette F. Edan, Ed.D., Director, 6404 E. Sweetwater, Scottsdale 85254

Vol. 130, No. 12 December 1973

11.4.74

THE AMERICAN JOURNAL OF PSYCHIATRY

Overview article

H. Keith H. Brodie and Melvin Sabshin on

Trends in Psychiatric Research

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

UNIVERSITY OF MICHIGAN LIBRARY





Hawaii '73 features discussions and selections from papers on:

- medicine in China
- peer utilization review
- 1972 self-assessment program
- differential diagnosis of organic vs. functional illness
- history of psychiatry in Hawaii
- the manic patient
- psychiatry and the National High Blood Pressure Education Program

Ask your SK&F Representative for your cassette. Ask him for information on our products, too.

Smith Kline & French Laboratories, Division of SmithKline Corp., makers of:

Thorazine®
brand of
chlorpromazine
100 mg. tablets

Stelazine®
brand of
trifluoperazine HCl
(product of SK&F Co.)
2 mg. tablets

Eskalith®
brand of
lithium carbonate
300 mg. tablets

Parnate®
brand of
tranylcypromine
10 mg. tablets

Dexedrine® (II)
brand of
dextroamphetamine
sulfate
5 mg. tablets

Compazine®
brand of
prochlorperazine
10 mg. tablets

SK-Bamate® (IV)
brand of
meprobamate
200 mg. tablets



THE AMERICAN JOURNAL OF PSYCHIATRY

OFFICIAL JOURNAL OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

The American Journal of Psychiatry, formerly *The American Journal of Insanity*, is published monthly by the American Psychiatric Association. Editorial office: 1700 Eighteenth Street, N.W., Washington, D.C. 20009; telephone (202) 232-7878.

Subscriptions: U.S. $15.00 per year, Canada and South America $15.75, other foreign $18.00; single issues: $1.75 plus postage.

APA members should direct changes of address and communications about nonreceipt of the *Journal* to the Manpower Division, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

Communications from nonmember subscribers and all business communications should be directed to Mr. Robert J. Lowe, Publications Services Division, at the same address.

Advertising representatives: Steven K. Herlitz, Inc., 850 Third Avenue, New York, N.Y. 10022.

Type set by Bru-El Graphic, Inc., 5265 Port Royal Road, Springfield, Va. 22151.

Printed by Dartmouth Printing Co., 69 Lyme Road, Hanover, N.H. 03755.

Second class postage paid at Washington, D.C., and additional mailing offices.

Indexed in *Abstracts for Social Workers, Biological Abstracts, Chemical Abstracts, Cumulative Index to Nursing Literature, Excerpta Medica, Hospital Literature Index, Index Medicus, International Nursing Index, Nutrition Abstracts*, and *Psychological Abstracts*.

Copyright© 1973, the American Psychiatric Association.

EDITOR
Francis J. Braceland, M.D.

ASSOCIATE EDITORS

H. Keith H. Brodie, M.D.
Jonathan O. Cole, M.D.
John M. Davis, M.D.
Dana L. Farnsworth, M.D.
Milton Greenblatt, M.D.
Zigmond M. Lebensohn, M.D.
Morris A. Lipton, M.D.
John C. Nemiah, M.D.
Chester M. Pierce, M.D.
Melvin Sabshin, M.D.
Rebecca Z. Solomon, M.D.
George Tarjan, M.D.

Managing Editor
Evelyn S. Myers

Assistant Managing Editor
Amy E. Shaughnessy

Senior Assistant Editor
Linda A. Loy

Assistant Editors
Laura M. Little
James Johnson
Christine H. Duewel

Editorial Assistant
Katherine P. Olinick

Art Services
John P. Halford

FORMER EDITORS: 1844–1965

Amariah Brigham, M.D.
T. Romeyn Beck, M.D.
Richard Dewey, M.D.
John P. Gray, M.D.
Henry M. Hurd, M.D.
G. Alder Blumer, M.D.
Edward N. Brush, M.D.
Clarence B. Farrar, M.D.



THE AMERICAN JOURNAL OF PSYCHIATRY

CONTENTS Vol. 130, No. 12 December 1973

1309 An Overview of Trends in Psychiatric Research: 1963–1972
H. Keith H. Brodie and Melvin Sabshin

1319 A Comment on the "Amotivational Syndrome" in Marijuana Smokers
David J. Kupfer, Thomas Detre, Jacqueline Koral, and Peter Fajans

1323 Emergency Psychiatric Hospitalization via Court Order: A Critique
Jack Zusman and Susan Shaffer

1327 A Computer Interview for Suicide-Risk Prediction
John H. Greist, David H. Gustafson, Fred F. Stauss, Glen L. Rowse, Thomas P. Laughren, and John A. Chiles

1333 Psychiatry in the United States and the USSR: A Comparison
Martin G. Allen

1338 Shared Ethnic Scotoma
Edith T. Shapiro and Henry Pinsker

1342 Psychiatric Residents: A Survey of Training Needs, Satisfactions, and Social Attitudes
Frederick E. Fried, Edmund G. Doherty, and Lolafaye Coyne

1346 1973 Anniversaries
George Mora

1351 True and False Experts: A Second Look
David S. Werman

TOPICAL PAPERS: *Some New Research Findings*

1355 Manic-Depressive Illness: Linkage with the Xg Blood Group
Ronald R. Fieve, Julien Mendlewicz, and Joseph L. Fleiss

1359 The Dimethyltryptamine-Forming Enzyme in Blood Platelets: A Study in Monozygotic Twins Discordant for Schizophrenia
Richard Jed Wyatt, Juan M. Saavedra, Robert Belmaker, Stephen Cohen, and William Pollin

1362 Growth Hormone and Prolactin in Unipolar and Bipolar Depressed Patients: Responses to Hypoglycemia and L-Dopa
Edward J. Sachar, Andrew G. Frantz, Norman Altman, and Jon Sassin

1367 Plasma Binding of Imipramine and Clinical Outcome
Alexander H. Glassman, Maria J. Hurwic, and James M. Perel

1370 Antagonistic Effects of Physostigmine and Methylphenidate in Man
David S. Janowsky, M. Khaled El-Yousef, John M. Davis, and H. Joseph Sekerke

EDITORIAL

1377 Hereditary Transmission of Psychiatric Illness
Samuel B. Guze

BRIEF COMMUNICATIONS

1379 Phases of Psychopathology After Assassination
Joseph C. Finney, Donald E. Skeeters, C. Dwight Auvenshine, and David F. Smith

1381 Prevention of Alcohol Withdrawal Seizures: The Roles of Diphenylhydantoin and Chlordiazepoxide
Emil Rothstein

1383 Self-Destructive and Suicidal Behaviors in a Neuropsychiatric Inpatient Facility
Judith Janaro Fabian, Michael P. Maloney, and Michael P. Ward

1386 Parkinsonism, L-Dopa, and Intelligence
Armand W. Loranger, Helen Goodell, Fletcher H. McDowell, John E. Lee, and Richard D. Sweet

1389 Interaction of Hypnotic Suggestion and Alpha Enhancement
T.A. Travis, C.Y. Kondo, and J.R. Knott

1391 Legal and Illegal Use of Methadone: One Year Later
Richard C. Stephens and Robert S. Weppner

1394 Family Structure in Three Cases of Anorexia Nervosa: The Role of the Father
Patricia Wold

1398 LETTERS TO THE EDITOR

1404 BOOK REVIEWS

ANNUAL INDEX

1414 Author Index

1426 Subject Index

A46 Index to Advertisers

Information for Contributors

SUBMISSION OF MANUSCRIPTS

Manuscripts should be submitted in duplicate to Francis J. Braceland, M.D., Editor, *The American Journal of Psychiatry*, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. Authors of numbered papers presented at the Association's annual meeting should submit two copies of the manuscript to the secretary of the session or notify the secretary that the manuscript will be sent to the *Journal* office later.

All numbered annual meeting papers become the property of the *Journal* although, due to space limitations, fewer than half can be published in the *Journal*. Release of a manuscript for publication elsewhere must be secured from the Editor.

Communications about a manuscript, by letter or telephone (202-232-7878), should include reference to the manuscript number. In the case of annual meeting papers, this is the number carried in the program booklet; in the case of other manuscripts, it is the number noted in the letter acknowledging receipt of the manuscript.

GENERAL POLICIES

Manuscripts are accepted for consideration with the understanding that they represent original material and that they are not being considered for publication elsewhere. Once a paper has been published in the *Journal*, which is a copyrighted publication, the legal ownership of all parts of the paper, including any illustrations, passes from the author to the *Journal*. If an individual or organization wishes to reprint material published in the *Journal*, written permission must first be secured from the Editor or Managing Editor.

Manuscripts are accepted on condition that the Editor be given the right to make revisions aimed at greater conciseness and clarity and to bring the manuscript into conformity with *Journal* style regarding capitalization, punctuation, etc.

The *Journal* does not hold itself responsible for statements made by contributors. Unless so stated, material in the *Journal* does not reflect the official attitude or position of the American Psychiatric Association or of the *Journal*'s Editorial Board.

SPECIFICATIONS FOR MANUSCRIPTS

Manuscripts should be typed in upper and lower case on one side only of letter-size bond (or other opaque) paper. All parts of the manuscript (including case reports, footnotes, references, etc.) should be double-spaced, with generous margins. Subheads should be inserted at reasonable intervals to aid in comprehension and to break the typographical monotony of lengthy texts. Abbreviations not easily recognized by the average reader should be explained.

Length. As a general rule the manuscript of a regular article should not exceed 10–12 typed pages, unless a special arrangement has been made with the Editor; Brief Communications should not exceed eight typed pages. Letters to the Editor should not exceed 500 words unless a special arrangement has been made with the Editor.

Author identification. The authors' affiliations and position titles should be provided and an address and telephone number given for the first-named author or the co-author who has been designated to handle the galley proofs and reprint requests. The number of authors should preferably not exceed four, with other collaborators being acknowledged in a footnote.

Precis. A brief precis is included at the beginning of each article: 60–100 words for regular articles, 40–60 words for Brief Communications. The author may prepare the precis himself or ask that the *Journal* staff prepare it, in which case the author may make any necessary changes on the galley proofs.

References. References should be typed double-spaced on a separate sheet of paper, to be attached at the end of the manuscript. They should be arranged according to their order of appearance in the text, where they should be indicated by numbers in parentheses. Reference citations should be restricted to closely pertinent papers; a complete review of the literature is rarely desirable, except in the case of review articles for which a special arrangement has been made with the Editor.

References should be typed in accordance with the style shown below for books and journal articles; chapters in books will be treated as journal articles with regard to capitalization. Up to three authors should be listed; one or more authors past the third will be designated "et al." Abbreviations of journal names should conform to the style used in *Index Medicus*.

1. Berne E: Principles of Group Treatment. New York, Oxford University Press, 1966, p 26
2. Schildkraut JJ: Tranylcypromine: effects on norepinephrine metabolism in rat brain. Am J Psychiatry 126:925–931, 1970
3. Blackwell B, Marley E, Price J, et al: Hypertensive interactions between monoamine oxidase inhibitors and foodstuffs. Br J Psychiatry 113:349–365, 1967
4. Brosin H: Communication systems of the consultation process, in The Psychiatric Consultation. Edited by Mendel W, Solomon P. New York, Grune & Stratton, 1968, pp 1–12

Tables and figures. Titles and headings of any tables and figures should be sufficiently clear that the meaning of the data is understandable without reference to the text. See recent issues of the *Journal* for the general requirements of style.

Each table should be typed on a separate sheet, attached at the end of the manuscript. The data should be arranged so that columns of like material read down, not across.

A complete set of figures, preferably in the form of glossy prints, should accompany each of the two copies of the manuscript. Most figures will be reduced to about 3¼ inches in width, the column width of the *Journal*; all elements of a figure should be prepared to withstand this reduction. Graphs should be finished drawings not requiring further artwork. Authors are urged to engage the services of a professional in the preparation of figures. Authors may be required to meet the costs of any further artwork that must be done in the editorial office.

AUTHOR'S CORRECTIONS

Galley proofs will be sent to the first-named author for corrections after the paper has been scheduled for publication; prompt return (preferably within 48 hours of receipt) is necessary to ensure publication in the assigned month. If an author expects to be away from his office for a long period of time after he has received the acceptance letter, he should inform the *Journal* office or arrange with a colleague to read the proofs. Authors are urged to keep changes on galleys to a minimum.

REPRINTS

An order form for reprints will be attached to the galley proofs submitted to authors for correction. Reprints are usually mailed to authors about a month after publication of the article. Requests from others to order reprints should be directed to the Editor; inclusion of a letter of permission from the senior author and a brief statement of the intended use of the reprints will expedite the processing of such requests.

THE AMERICAN PSYCHIATRIC ASSOCIATION

1700 Eighteenth Street, N.W., Washington, D.C. 20009

OFFICERS 1973–1974

President: ALFRED M. FREEDMAN
President-Elect: JOHN P. SPEIGEL
Vice-President: MILDRED MITCHELL-BATEMAN
Vice-President: HAROLD M. VISOTSKY
Secretary: ROBERT W. GIBSON
Treasurer: JACK WEINBERG

ASSEMBLY OF DISTRICT BRANCHES

Speaker: WARREN S. WILLIAMS
Speaker-Elect: ROBERT B. NEU
Recorder: W. PAYTON KOLB

BOARD OF TRUSTEES

For three years: LEON EISENBERG, HERBERT KLEMMER, ALAN A. STONE, PERRY C. TALKINGTON
For two years: EWALD W. BUSSE, HENRIETTE R. KLEIN, MELVIN SABSHIN, JOHN R. SAUNDERS
For one year: ROBERT S. GARBER, JOHN E. NARDINI, IRVING PHILIPS, CHARLES B. WILKINSON

CHAIRMEN OF COUNCILS AND COMMITTEES

CONSTITUTIONAL COMMITTEES

Tellers
MORRIS KLEINERMAN

Constitution and By-Laws
WINFRED OVERHOLSER, JR.

Ethics
ROBERT A. MOORE

Membership
ALEXANDER LEVINE

Nominating
HOWARD P. ROME

Budget
JOHN S. VISHER

COUNCIL ON MEDICAL EDUCATION AND CAREER DEVELOPMENT

ALBERT SILVERMAN

History
DAVID F. MUSTO

Medical Education
HAROLD I. KAPLAN

School Consultation
SHELDON D. GLASS

Conference on Family Life Education
ARNOLD M. KALLEN

Graduate Education

Certification in Administrative Psychiatry
ARCHIE R. FOLEY

Research Training
FREDERIC G. WORDEN

Education of Physicians

Continuing Education Committee
ROBERT A. SENESCU

Continuing Education Task Force
JAMES NAIMAN

COUNCIL ON PROFESSIONS AND ASSOCIATIONS

LEWIS L. ROBBINS

Psychiatry and the Law
STANLEY L. PORTNOW

Liaison with American Hospital Association
GERALD R. CLARK

Liaison with American College of Physicians
CHARLES P. NEUMANN

Psychiatric Nursing
WILLIAM E. STONE

Right to Treatment
BERNARD DIAMOND

Confidentiality as It Relates to Third Parties
MAURICE GROSSMAN

Religion and Psychiatry
ABRAHAM N. FRANZBLAU

COUNCIL ON EMERGING ISSUES

EDWARD T. AUER

Women in Psychiatry
NANCY A. ROESKE

Psychiatric Involvement in Family Planning
EUGENE B. BRODY

Psychosurgery
JOHN DONNELLY

Psychohistory
CHARLES HOFLING

COUNCIL ON RESEARCH AND DEVELOPMENT

RUSSELL R. MONROE

Drug Abuse
DANIEL X. FREEDMAN

Nomenclature and Statistics
HENRY BRILL

Clinical Aspects of the Violent Individual
DONALD P. KENEFICK *and* JOHN R. LION

Methadone Therapy and Narcotic Antagonists
ROGER E. MEYER

Lithium Therapy
IRVIN M. COHEN

Meditation
JAMES MORGAN

Effects of Television on Mental Health
JAMES H. RYAN

Evaluation Research in Community Mental Health Centers
GERALD L. KLERMAN

COUNCIL ON INTERNATIONAL AFFAIRS

NORMAN ROSENZWEIG

Joint Meeting in Australia 1975
ALFRED AUERBACK

Inter-American Council of Psychiatric Associations
HOWARD P. ROME

Psychological Aspects of Near Eastern Studies
WILLIAM D. DAVIDSON

Ethnocentricity Among Psychiatrists
RAMON PARRES

Transcultural Aspects of Mental Health of Children
JORGE M. VELASCO-ALZAGA

Liaison with International and Foreign Psychiatric Organizations
NATHAN S. KLINE

Joint Meeting with Scandinavian Psychiatric Societies
ROBERT S. GARBER

COUNCIL ON MENTAL HEALTH SERVICES

JAMES C. JOHNSON

Financing of Mental Health Care
WILLIAM H. GOLDMAN

Federal Government Health Services
STEWART BAKER

Childhood and Adolescence
VIOLA BERNARD

Private Psychiatric Hospitals
JOHN H. HOUCK

Suicide Prevention
MATHEW ROSS

Nursing Homes and Other Extended Care Facilities
ARTHUR L. ARNOLD

APA Standards for Psychiatric Facilities
WILLIAM S. ALLERTON

Psychiatric Rehabilitation in Correctional Systems
FRANCIS A. TYCE

Professional Standards Review Organizations
FRANK SULLIVAN

COUNCIL ON INTERNAL ORGANIZATION

MILTON GREENBLATT

Program
H. KEITH H. BRODIE

Film Review
EDWARD A. MASON

Closed-Circuit TV Presentations
MILTON BERGER

Arrangements
BENJAMIN JEFFRIES

Conventions
ALEXANDER SIMON

Scientific Exhibits
ROBERT FROELICH

Awards for Scientific Exhibits
SARA DUBO

Public Information
JAMES P. CATTELL

Member Insurance and Retirement Plans
CHESTER TRENT

Trustees of APA Retirement Plan
SANFORD L. BILLET

House
DANIEL JAFFE

Hospital & Community Psychiatry Achievement Awards Board
PRESTON HARRISON

Hospital & Community Psychiatry Program Committee
NAT T. WINSTON, JR.

Isaac Ray Award
JOHN K. TORRENS

Manfred S. Guttmacher Award
JONAS R. RAPPEPORT

Hofheimer Prize
DONALD F. KLEIN

McGavin Award
NORBERT B. ENZER

Vestermark Prize
BERTRAM S. BROWN

Grants and Awards
JACK WEINBERG

Residents
THOMAS A. RODGERS

COUNCIL ON NATIONAL AFFAIRS

JAMES M. BELL

Black Psychiatrists
JAMES P. COMER

Delivery of Psychiatric Services in Poverty Areas
QUENTIN A.F. RAE-GRANT *and* ORLANDO B. LIGHTFOOT

Mental Health of Spanish-Speaking People in the U.S.
ANGEL GOMEZ

Indian Affairs
MORTON BEISER

Comprehensive Health Planning
ROBERT L. WILLIAMS

Third-Party Intervention in Community Crises
FRANK OCHBERG

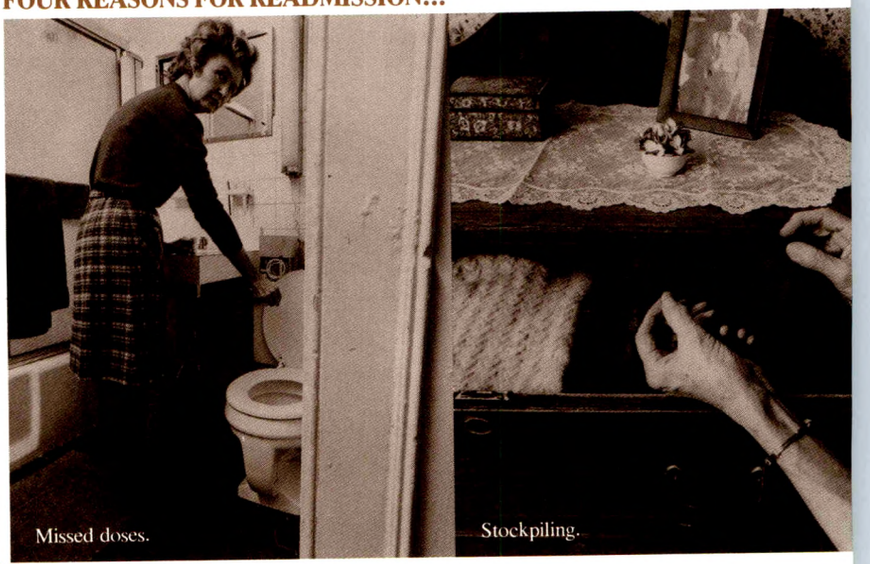
Legislative Network
HAYDEN H. DONAHUE

For schizophrenic patients...

A way out

that helps them stay out

FOUR REASONS FOR READMISSION...

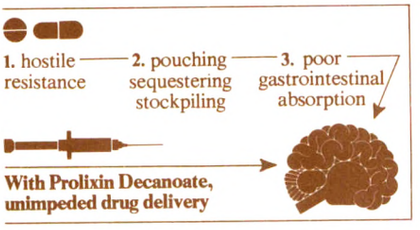


Missed doses.

Stockpiling.

Controlled Drug Delivery with
PROLIXIN® DECANOATE (FLUPHENAZINE DECANOATE INJECTION)
Puts control of the schizophrenic in your hands with injections 1 to 3 weeks apart or longer, with an average duration of effect of about 2 weeks

Controlled drug delivery helps prevent disruption of therapy—one of the commonest causes of psychotic relapse. For the inpatient it means unimpeded drug delivery with improved chances of discharge.



For the outpatient it means improve chances for prolonged remission: "...th duration of remission and the incidenc of relapse are directly related to keepir the patient medicated after his return t the community."[1]

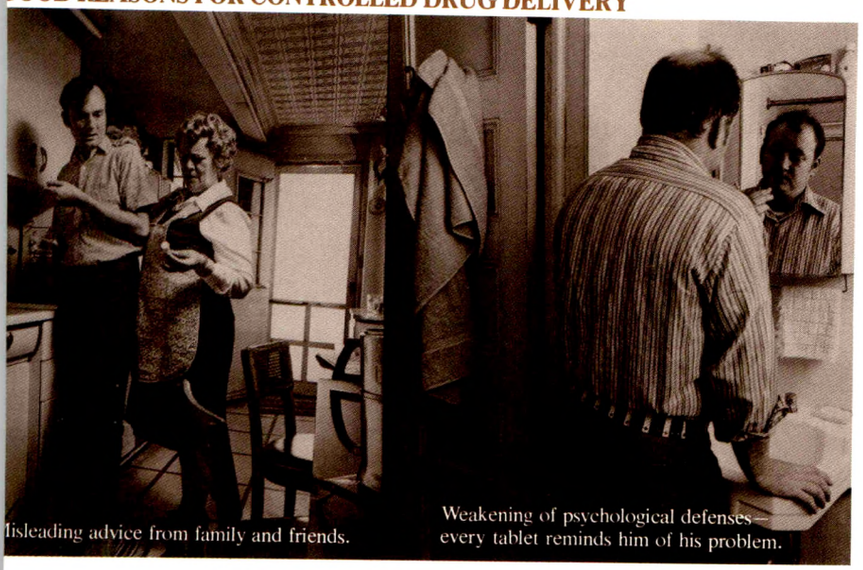
Controlled drug delivery helps the inpatient out

- Keeps the patient medicated...help make him more manageable, more co fortable, and more amenable to tot treatment. With oral medication, on th other hand, approximately one out every five patients does not take his me ication, even when administered by th nursing staff.[2]
- Eliminates the problem of missed, lo or hidden doses. Prevents stockpiling.
- Assures regular medication intake.
- Lightens responsibilities of the hospit staff...simplifies patient management b obviating the need for multiple doses.
- Increases the likelihood of discharg In one study[3] of 24 long-term hospit patients treated with Prolixin Decanoa (Fluphenazine Decanoate Inje tion) every 7 days to 3 weeks:

DISCHARGED	CONSIDERED DISCHARGEABLE	NO IMPROVEME
13	4	7

Dischargeability "may also have been e hanced because the staff, the patie and the family were assured of an a equate and regular medication intake."

GOOD REASONS FOR CONTROLLED DRUG DELIVERY



Misleading advice from family and friends.

Weakening of psychological defenses—every tablet reminds him of his problem.

Controlled drug delivery helps keep the outpatient out

Helps assure continuity of medication ..makes prolonged remission more likely. With oral medication, on the other hand, "approximately 50% of all discharged psychotic patients fail to take even the first dose of their outpatient medication."[2]

Enhances chances for rehabilitation... promotes acceptance socially, in the family, and on the job because of sustained control of symptomatology.

Eases family adjustment by eliminating concern about "taking his medicine."

Avoids the potential dangers of stockpiling, particularly for the suicidal.

Once administered, therapy cannot be altered by the patient, by his family, or by anyone else.

The unique advantages of controlled drug delivery apply equally to the patient who has never been hospitalized. They are advantages that can help make custodial care unnecessary as long as treatment continues.

Controlled drug delivery saves time, reduces cost in the hospital, clinic, office

Saves time in the hospital:

18 PATIENTS	18 PATIENTS
8 a.m. ¾ hr. 2 p.m. ¾ hr. 6 p.m. ¾ hr.	1 injection every 14 days for most patients
=2¼ hrs. nursing time	4 minutes required for each injection (approx.)
2¼ hrs. × 14 days **=31½ hrs. of nursing time every 14 days**	**=1 hr. 10 minutes nursing time in 14 days**
NURSING TIME SAVED IN 14 DAYS: 30 hours, 20 minutes[4]	

Saves time in the clinic and in the office: Most patients report for their injections only once in every two-week period.

Prolixin Decanoate (Fluphenazine Decanoate Injection) also offers the convenience of easy-to-use Unimatic® Syringes: Unimatic single-dose preassembled syringes and Unimatic cartridge-needle units with a reusable plastic holder. Vials of 5 cc. Prolixin Decanoate are available for use with dry syringes and needles (at least 21 gauge). Use of a wet needle may cause the solution to become cloudy.



N.B. Extrapyramidal reactions occur frequently. Most often they are reversible and can usually be controlled by administration of antiparkinsonian drugs. However, in some instances, they are persistent—particularly in the case of tardive dyskinesia (see Adverse Reactions section of Brief Summary). Patients should be forewarned and reassured.

References: 1. Kinross-Wright, V. J.: Cited in Med. Tribune, Sept. 13, 1965, pp. 1, 27. 2. Goldberg, H. L., DiMascio, A. and Chaudhary, B.: Psychosomatics 11:173, May-June 1970. 3. Keskiner, A. et al.: Arch. Gen. Psychiatry 18:477, Apr. 1968. 4. Platt, R.: Br. J. Social Psychiatry 2:187, 1968.

Controlled Drug Delivery *with* PROLIXIN® DECANOATE FLUPHENAZINE DECANOATE INJECTION)

For product Brief Summary, see following page.

SQUIBB HOSPITAL DIVISION

Controlled Drug Delivery

in schizophrenia with

PROLIXIN® DECANOATE

(FLUPHENAZINE DECANOATE INJECTION

BRIEF SUMMARY
Prolixin Decanoate (Fluphenazine Decanoate Injection) provides 25 mg. fluphenazine decanoate per cc. in a sesame oil vehicle with 1.2% (w/v) benzyl alcohol as a preservative.

CONTRAINDICATIONS: In presence of suspected or established subcortical brain damage. In patients who have a blood dyscrasia, liver damage or renal insufficiency, or who are receiving large doses of hypnotics, or who are comatose or severely depressed. In patients who have shown hypersensitivity to fluphenazine; cross-sensitivity to phenothiazine derivatives may occur.

Not intended for use in children under 12.

WARNINGS: Mental and physical abilities required for driving a car or operating heavy machinery may be impaired by use of this drug. Physicians should be alert to the possibility that severe adverse reactions may occur which require immediate medical attention. Potentiation of effects of alcohol may occur. Safety for use during pregnancy has not been established; weigh possible hazards against potential benefits if administered during pregnancy. Safety and efficacy in children have not been established because of inadequate experience in use in children.

PRECAUTIONS: Caution must be exercised if another phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reactions because of the possibility of cross-sensitivity. When psychotic patients on large doses of a phenothiazine drug are to undergo surgery, hypotensive phenomena should be watched for; less anesthetics or central nervous system depressants may be required. Because of added anticholinergic effects, fluphenazine may potentiate the effects of atropine.

Use fluphenazine decanoate cautiously in patients exposed to extreme heat or phosphorus insecticides; in patients with ulcer disease history since aggravation of peptic ulcer has occurred; in patients with history of convulsive disorders since grand mal convulsions have occurred; and in patients with special medical disorders such as mitral insufficiency or other cardiovascular diseases, and pheochromocytoma. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible dyskinesia.

Fluphenazine decanoate should be administered under the direction of a physician experienced in the clinical use of psychotropic drugs. Periodic checking of hepatic and renal functions and blood picture should be done. Renal function of patients on long-term therapy should be monitored; if BUN becomes abnormal, treatment should be discontinued. "Silent pneumonias" are possible.

ADVERSE REACTIONS: *Central Nervous System*—Extrapyramidal symptoms are most frequently reported. These include pseudoparkinsonism, dystonia, dyskinesia, akathisia, oculogyric crises, opisthotonos, and hyperreflexia; most often these are reversible, but they may be persistent. One can expect a higher incidence of such reactions with fluphenazine decanoate than with less potent piperazine derivatives or straight-chain phenothiazines. The incidence and severity will depend more on individual patient sensitivity, but dosage level and patient age are also determinants. As these reactions may be alarming, the patient should be forewarned and reassured. These reactions can usually be controlled by administration of antiparkinsonian drugs such as benztropine mesylate or intravenous Caffeine and Sodium Benzoate Injection U.S.P., and by subsequent reduction in dosage.

Persistent Tardive Dyskinesia: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on long-term therapy or may occur after discontinuation of drug. The risk seems greater in elderly patients, especially females, on high dosages. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia; usually the symptoms are not alleviated by antiparkinsonism agents. If the symptoms appear, discontinuation of all antipsychotic agents is suggested. The syndrome may be masked if treatment is reinstituted, or drug dosage increased, or a different antipsychotic agent used. Reports are that fine vermicular movements of the tongue may be an early sign of the syndrome which may not develop if medication is stopped at that time.

Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and reactivation or aggravation of psychotic processes may be encountered. If drowsiness or lethargy occur, the dosage may have to be reduced. Dosages, far in excess of the recommended amounts, may induce a catatonic-like state.

Autonomic Nervous System—Hypertension and fluctuations in blood pressure have been reported. Although hypotension is rarely a problem, patients with pheochromocytoma, cerebral vascular or renal insufficiency or severe cardiac reserve deficiency such as mitral insufficiency appear to be particularly prone to this reaction and should be observed carefully. Supportive measures including intravenous vasopressor drugs should be instituted immediately should severe hypotension occur; Levarterenol Bitartrate Injection U.S.P. is the most suitable drug; *epinephrine should not be used* since phenothiazine derivatives have been found to reverse its action. Nausea, loss of appetite, salivation, polyuria, perspiration, dry mouth, headache and constipation may occur. Reducing or temporarily discontinuing the dosage will usually control these effects. Blurred vision, glaucoma, bladder paralysis, fecal impaction, paralytic ileus, tachycardia, or nasal congestion have occurred in some patients on phenothiazine derivatives.

Metabolic and Endocrine—Weight chang peripheral edema, abnormal lactation, gynec mastia, menstrual irregularities, false result on pregnancy tests, impotency in men an increased libido in women have occurre in some patients on phenothiazine therap

Allergic Reactions—Itching, erythema, urt caria, seborrhea, photosensitivity, eczem and exfoliative dermatitis have been reporte with phenothiazines. The possibility of an phylactoid reactions should be borne in min

Hematologic—Blood dyscrasias includin leukopenia, agranulocytosis, thrombocyt penic or nonthrombocytopenic purpur eosinophilia, and pancytopenia have bee observed with phenothiazines. If soreness the mouth, gums or throat or any symptom of upper respiratory infection occur and co firmatory leukocyte count indicates cellula depression, therapy should be discontinue and other appropriate measures institute immediately.

Hepatic—Liver damage manifested by ch lestatic jaundice, particularly during the fir months of therapy, may occur; treatme should be discontinued. A cephalin floccu tion increase, sometimes accompanied b alterations in other liver function tests, ha been reported in patients who have had r clinical evidence of liver damage.

Others—Sudden deaths have been reporte in hospitalized patients on phenothiazin Previous brain damage or seizures may b predisposing factors. High doses should b avoided in known seizure patients. Short before death, several patients showed fla ups of psychotic behavior patterns. Autop findings have usually revealed acute fulr nating pneumonia or pneumonitis, aspiratic of gastric contents, or intramyocardial sions. Although not a general feature of f phenazine, potentiation of central nervo system depressants such as opiates, anal sics, antihistamines, barbiturates, and al hol may occur.

Systemic lupus erythematosus-like s drome, hypotension severe enough to cau fatal cardiac arrest, altered electrocard graphic and electroencephalographic tracin altered cerebrospinal fluid proteins, cerebr edema, asthma, laryngeal edema, and ang neurotic edema; with long-term use, sk pigmentation and lenticular and corne opacities have occurred with phenothiazin Local tissue reactions occur only rarely wi injections of fluphenazine decanoate.

For full prescribing information, cons package insert.

HOW SUPPLIED: 1 cc. Unimatic® sing dose preassembled syringes and cartrid needle units, and 5 cc. vials.

SQUIBB HOSPITAL DIVISION

© 1973 E. R. Squibb & Sons, Inc. H423-02
Princeton, N. J. 08540



Suspicious and hostile?...Or accessible?

While psychotic symptoms remain acute, the barrier between you and the overly suspicious, hostile patient may be insurmountable. Prompt intervention with HALDOL (haloperidol) often makes it possible for you to reach... relate...rehabilitate.

And rapport with such patients is further enhanced because HALDOL usually leaves patients alert and relatively non-sedated.

accessibility often begins with

HALDOL® (haloperidol)

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn page.

© McNeil Laboratories, Inc., 1973

Haldol®
(HALOPERIDOL)

a first choice for prompt rapport

A Dosage Form for Every Need:

4 tablet strengths for convenience in individualizing dosage: ½ mg., 1 mg., 2 mg. and 5 mg.

An undetectable, tasteless Liquid Concentrate for the patient unable or unwilling to swallow tablets: 2 mg. per cc.

A rapid-acting Injection for psychiatric emergencies: 5 mg. per cc., with 0.5 mg. methylparaben and 0.05 mg. propylparaben per cc., and lactic acid for pH adjustment to 3.4±0.2.

Summary of Directions for Use

Indications: For the treatment of such symptoms as moderate to severe agitation, anxiety and tension, assaultiveness, delusions, hallucinations, hostility, and hyperactivity when they are manifestations of psychosis including schizophrenia, the manic type of manic depressive illness, or psychotic reactions associated with organic brain syndromes or mental retardation. For the control of tics and vocal utterances of Gilles de la Tourette's Syndrome.

Contraindications: HALDOL (haloperidol) is contraindicated in patients who are severely depressed, comatose, have CNS depression due to alcohol or other centrally-acting depressants, have Parkinson's disease or are hypersensitive to this drug.

Warnings: ***Usage in Pregnancy***—Safe use of HALDOL (haloperidol) in pregnancy and lactation has not been established; therefore, its use in pregnancy, in nursing mothers, or in women of childbearing potential requires that the possible benefits of the drug be weighed against the potential hazards. A case of phocomelia in an infant whose mother received haloperidol along with a number of other medications during the first trimester of pregnancy has been reported (a causal relationship was not established in this case). Animals receiving 2 to 20 times the maximum human dose of HALDOL orally and/or parenterally showed increased incidence of resorption, reduced fertility, delayed delivery, dose-related pup mortality (presumably due to lack of maternal care reflecting CNS depression).

Usage in Children—Safety and effectiveness in children have not been established; therefore, this drug is not recommended for use in the pediatric age group.

General—Cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol. It has been postulated that lethargy and decreased sensation of thirst may lead to dehydration, hemoconcentration and reduced pulmonary ventilation. If these signs and symptoms appear, especially in the elderly, the physician should institute remedial therapy promptly. Although not reported with HALDOL (haloperidol), decreased serum cholesterol and/or cutaneous and ocular changes have been reported in patients receiving chemically-related drugs. HALDOL may impair the mental and/or physical abilities required for the performance of hazardous tasks such as operating machinery or driving a motor vehicle. The ambulatory patient should be warned accordingly. The use of alcohol should be avoided due to possible additive effects and hypotension.

Precautions: HALDOL (haloperidol) should be administered cautiously to patients: (1)—with severe cardiovascular disorders, because of the possibility of transient hypotension and/or precipitation of anginal pain. Should hypotension occur and a vasopressor be required, *epinephrine should not be used* since HALDOL may block its vasopressor activity and paradoxical further lowering of blood pressure may occur. (2)—receiving anticonvulsant medication, because HALDOL may lower the convulsive threshold, although it will *not* increase the effects of anticonvulsant medication. Adequate anticonvulsant therapy should be maintained concomitantly. (3)—with known allergies, or with a history of allergic reactions to drugs. (4)—receiving anticoagulants, since an isolated instance of interference occurred with the effects of one anticoagulant (phenindione).

If concomitant anti-Parkinson medication is required, it may have to be continued after haloperidol is discontinued because of the difference in excretion rates. If both are discontinued simultaneously, extrapyramidal symptoms may occur. Intraocular pressure may increase when anticholinergic drugs, including anti-Parkinson agents, are administered concomitantly with HALDOL. When HALDOL is used to control mania in cyclic disorders there may be a rapid mood swing to depression.

Adverse Reactions: ***CNS Effects:*** *Extrapyramidal Reactions*—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involved Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. *Other CNS Effects*—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. ***Cardiovascular Effects:*** Tachycardia and hypotension. ***Hematologic Effects:*** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. ***Liver Effects:*** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. ***Dermatologic Reactions:*** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. ***Endocrine Disorders:*** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. ***Gastrointestinal Effects:*** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. ***Autonomic Reactions:*** Dry mouth, blurred vision, urinary retention and diaphoresis. ***Respiratory Effects:*** Laryngospasm, bronchospasm and increased depth of respiration.

Complete dosage information available in insert which accompanies each package (or on request).

The use of the injectable form is intended for the acutely agitated psychotic patient with moderately severe to very severe symptoms.

IMPORTANT: Full directions for use should be read before HALDOL (haloperidol) is administered or prescribed. 11/72

McNEIL McNeil Laboratories, Inc.
Fort Washington, Pa. 19034

MORE THAN 30 YEARS...

have proven the dependability and effectiveness of REITER ELECTROSTIMULATORS in psychiatry! Research and constant improvements to meet the standards of improved techniques have kept Reiter instruments

THE WORLD'S MOST ACCEPTED ELECTROSTIMULATORS

The Two Popular Models— **PORTABLE FOR OFFICE AND CLINIC**



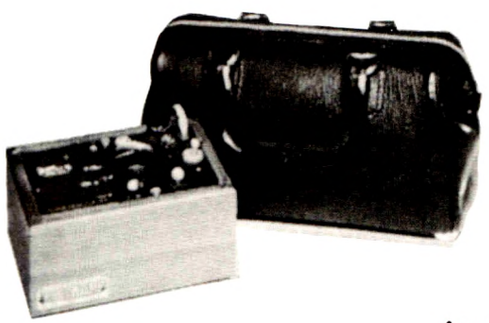
The Reiter MODEL SOS—THE ONE INSTRUMENT FOR ALL ESTABLISHED TECHNIQUES, provides the fullest range of safest therapies. For painless, gentle stimulation of the conscious patient to relieve anxiety, depression, etc. Maximum safety, no additives—patient conscious and cooperating with therapy.

The SOS has also been used universally for Convulsive Therapy, Non-Convulsive Therapies, Electro-Sleep Therapy, Focal Treatment, Mono-Polar Treatment, Barbiturate Coma (and other respiratory problems), Mild Sedac, Deep Sedac Therapy, Pre-Convulsive Sedac, Post-Convulsive Sedac, Neurological Conditions, and Measurement Procedures.

Available with this redesigned model, on request, the following special-purpose electrodes —a Multi-Polar "Collar" type for Sleep Therapy, a "Horseshoe" assembly for quicker, surer application with one hand at last moment before ECT treatment, and a "Unilateral" type assembly.

Also built-in on request, an **automatic switch** for quicker build up to therapeutic ranges of Sedac.

SPECIAL MODEL SOS available without unidirectional convulsive current.



The Reiter Compact MOL-AC II—The smallest, lightest, least expensive and most reliable, clinically proven A.C. shock therapy instrument. Less confusion than from similar A.C. equipment. Now available with redesigned, improved panel. This compact instrument is only 3 x 5 inches, weighs but 3 lbs., yet provides full positive control of glisando effect over entire voltage range, as well as a positive manual control of time. There are NO complicated settings of dials, NO waiting for resetting of time devices, no warm-up delays.

An officially approved, extremely durable instrument which has earned world-wide professional acceptance, the MOL-AC II is economically priced with a fine, genuine leather physician's bag included.

Other Models Still Available: The CW47, original therapeutic cerebral stimulator with only 3 of the 9 treatment current selections available on Model SOS.

For more detailed information, and bibliography of over 200 references, write to:

REUBEN REITER, Sc.D., INC. 187 Sylvan Ave., Leonia, N.J. 07605 — Tel. (201) 944-1211

Help release her from severe anxiety. Then she can open up to you.



Only with relief of the severe anxiety that often blocks verbalization can many patients expect to progress in therapy. To this end, Serax may prove beneficial, for it is now well established as an effective antianxiety adjunct. Serax offers flexibility as well. Dosage can be readily adjusted to individual needs. To the point where the patient may frequently resume normal work activities.

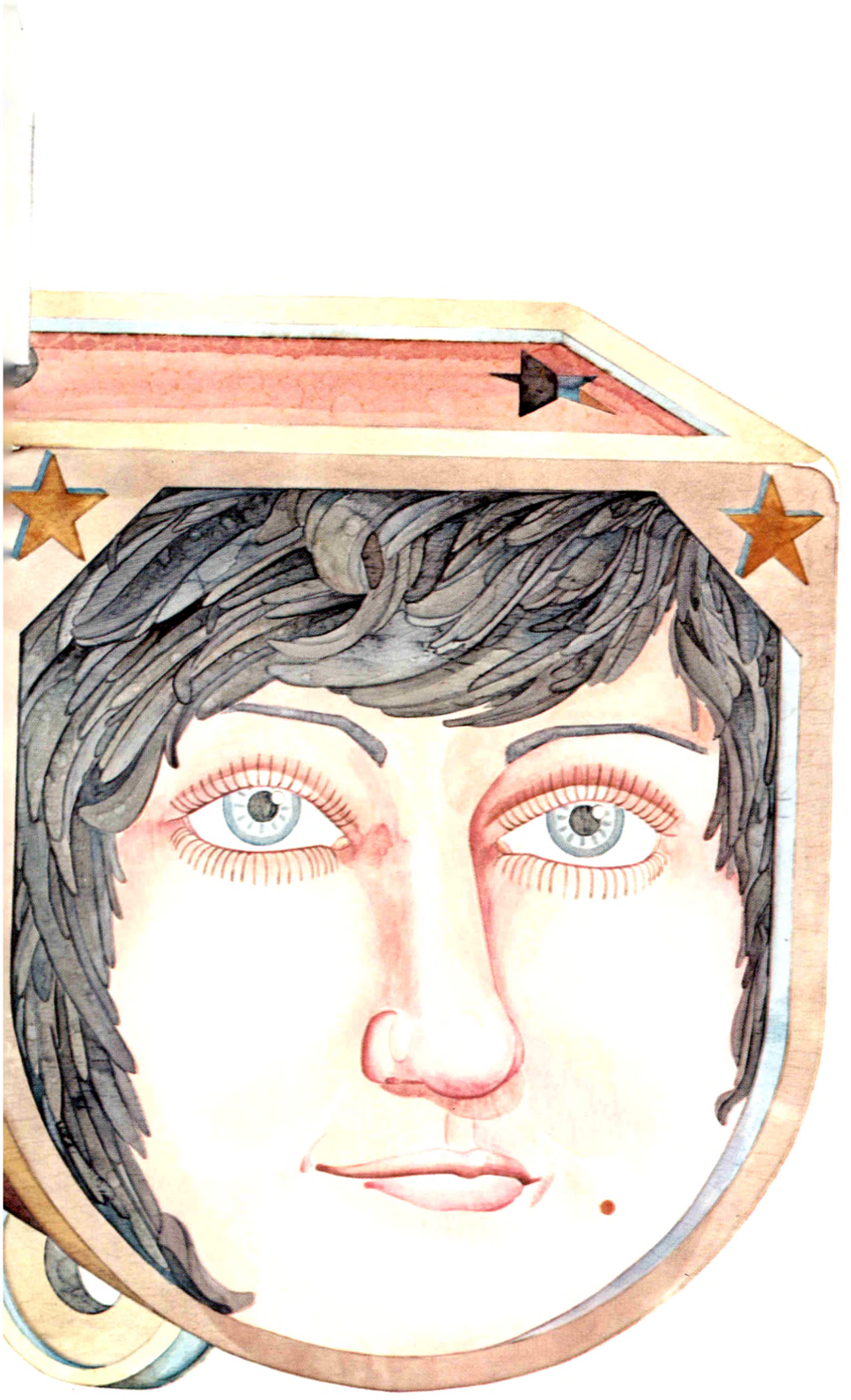
As with other CNS-acting drugs, patients should be cautioned against driving automobiles or operating dangerous machinery until it is known that they do not become drowsy or dizzy on oxazepam therapy. When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly or where a drop in blood pressure might lead to cardiac complications.

In severe anxiety

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa 19101

Please see important information on page after next.



Help release her from severe anxiety.



Indications: Oxazepam is indicated for the management and control of anxiety, tension, agitation, irritability and related symptoms. Such symptoms are commonly seen in patients with a diagnosis of psychoneurotic reaction, psychophysiological reaction, personality disorder, or in patients with underlying organic disease.

Anxiety associated with depression is also responsive to oxazepam therapy.

This product has been found particularly useful in the management of anxiety, tension, agitation and irritability in older patients.

Alcoholics with acute tremulousness, inebriation or with anxiety associated with alcohol withdrawal are responsive to therapy.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Warning: *Use in Pregnancy:* Safety for use in pregnancy not established.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to self-overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam; tablets of 15 mg. oxazepam.

Serax®
(oxazepam)

Wyeth Laboratories
Philadelphia, Pa. 19101

from USV
an inexpensive way to "write"
chlorpromazine

CHLOR-PZ™

BRAND OF

CHLORPROMAZINE HCl

The cost of chlorpromazine has been reduced. Introducing CHLOR-PZ, a quality chlorpromazine at a lower price. You can prescribe CHLOR-PZ in a wide variety of strengths for your patients. And who knows... maybe they'll be just a little less disturbed knowing their prescription costs less.

CHLOR-PZ.
It lowers the price of long-term therapy.

USV Pharmaceutical Corp.
Tuckahoe, N.Y. 10707

Indications: Certain manifestations of psychotic disorders; nausea and vomiting; restlessness and apprehension prior to surgery; acute intermittent porphyria; as adjunct in tetanus treatment.
Contraindications: Comatose states, presence of large amounts of CNS depressants, bone marrow depression, or hypersensitivity to phenothiazines.
Warnings: Caution patients about performing hazardous tasks (e.g., operating vehicles or machinery). Avoid concomitant use with alcohol or other CNS depressants. May counteract antihypertensive effect of guanethidine and related compounds. Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine. In rodents, embryotoxicity, increased neonatal mortality, and nursing transfer of the drug have been observed, with the possibility of permanent neurological damage. Use with extreme caution in presence of glaucoma or prostatic hypertrophy.
Precautions: Use cautiously in persons with cardiovascular, liver, acute or chronic respiratory disease (particularly children), or with a history of epilepsy. Due to cough reflex suppression, aspiration of vomitus and mucus is possible. May prolong or intensify the action of CNS depressants (reduce dosage of concomitant CNS depressants), organophosphate insecticides, heat, atropine and related drugs. Anticonvulsant action of barbiturates is not intensified. May block or reverse epinephrine action. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.
Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, infertility; gynecomastia, changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis; hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment.
Note: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.
How Supplied: CHLOR-PZ tablets—10, 25, 50, 100 and 200 mg., in bottles of 100 and 1000.

BEFORE PRESCRIBING, CONSULT PACKAGE INSERT FOR COMPLETE PRODUCT INFORMATION.

USV
PHARMACEUTICALS


• nervous • anxious
• irritable
• fatigued
• restless nights
While you're calming her down with a tranquilizer...

treat what may be her real problem with

PREMARIN® BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

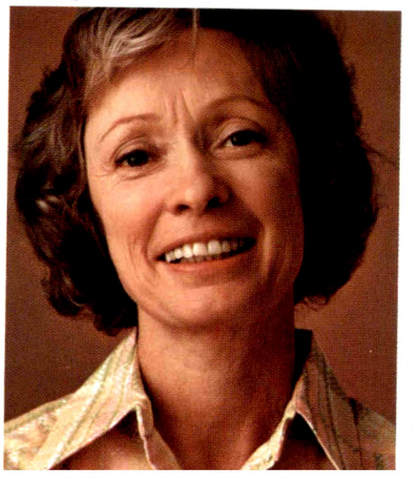
She's come to you in a highly emotional state, with complaints of anxiety, nervousness, insomnia, and depression. And treatment with a psychotherapeutic agent may be appropriate for immediate relief of symptoms.

But considering her age, and her irregular menses, such symptoms may indicate an underlying estrogen deficiency... and the need for additional, more comprehensive therapy.

PREMARIN, by offering sound specific natural estrogen replacement, can provide such therapy ...relieve estrogen-related emotional symptoms of the menopause by treating their cause. Anxiety and depression related to estrogen deficiency usually respond to replacement therapy in a relatively short time.[1,2] Other "psychogenic" symptoms such as headaches, crying spells, insomnia, feelings of weakness and fatigue may also be relieved.[1,3-5]

And in a large majority of patients, PREMARIN imparts a renewed sense of well-being.[6] At the same time, PREMARIN helps control hot flushes, sweats, genital tissue atrophy, and, in selected cases, helps retard postmenopausal osteoporotic bone degeneration.*

When there is uncertainty as to the origin of emotional symptoms in the menopausal woman, a therapeutic trial with PREMARIN helps relieve those complaints that are estrogen-related...while helping to identify those that aren't.[7]



for estrogen-related emotional symptoms of the menopause

*Conjugated Estrogens Tablets have been evaluated as "probably" effective for postmenopausal osteoporosis.

See last page of advertisement for prescribing information.

when her real problem is estrogen deficiency



PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

contains only natural estrogens

for estrogen-related emotional symptoms

BRIEF SUMMARY
(For full prescribing information, see package circular.)

PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"**Probably**" **effective:** For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding
(See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000. No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100. No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

References: 1. Kerr, M.D.: Mod. Treatm. *5*:587 (May) 1968. 2. Penningroth, R.P., and Tourney, G.: Postgrad. Med. *46*:118 (July) 1969. 3. Rhoades, F.P.: J. Amer. Geriat. Soc. *15*:346 (Apr.) 1967. 4. Astwood, E.B., in Goodman, L.S., and Gilman, A. (Eds.): The Pharmacological Basis of Therapeutics, ed. 4, New York, The Macmillan Company, 1970, chap. 69, p. 1538 ff. 5. Kupperman, H.S.: Med. Aspects of Hum. Sexuality *1*:64 (Sept.) 1967. 6. Tramont, C.B.: Geriatrics *21*:212 (Nov.) 1966. 7. Kaufman, S.A., in Sturgis, S.H., and Taymore, M. (Eds.): Progress in Gynecology, New York, Grune & Stratton, Inc., 1970, vol. 5, p. 179.

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

7340

PSYCHIATRIST

$26,000 – $30,000 per annum

The Ministry of Health, Oxford Mental Health Centre in Woodstock has a vacancy for a Team Leader, Psychiatric Treatment Unit. This is a combined psychiatric/adult retardation facility of some 850 beds, eighty-five of which are assigned to the Psychiatric Services. We are in the process of expanding psychiatric programs and services and provide an excellent opportunity for anyone interested in treatment, clinical work and administration, teaching, and development of community based programs as well as a possible university affiliation. A team approach is favoured with close co-operation with para-medical services. Crisis intervention emergency and clinic involvement and consultation as well as day or extended care and group care programs are available, or to be further developed.

Qualifications include a licence to practice medicine in Ontario and certification in Psychiatry (R.C.P.S.) Canada, or comparable specialist standing in another jurisdiction.

Woodstock has a population of 25,000 located 90 miles from Toronto and 30 miles from London. Both are university centres, easily reached by throughways. For further information, apply to the Personnel Officer, Oxford Mental Health Centre, Woodstock, Ontario, Canada.

The American Journal of Psychiatry

The January 1974 issue will feature

Leston L. Havens on

The Existential Use of the Self

ELAVIL®
(AMITRIPTYLINE HCl|MSD)
useful in many therapeutic settings



In the psychiatrist's office. Whatever other therapeutic facilities have been developed, the psychiatrist's office still represents the setting in which the psychoanalytic process recognizes its fullest potential. Frequently, however, an antidepressant must be employed to foster a working therapeutic relationship. With effective symptomatic relief often provided by ELAVIL (Amitriptyline HCl, MSD), depressed patients may be able to concentrate on underlying factors instead of somatic manifestations.

In the general hospital. The general hospital today usually provides a psychiatric unit where depressed patients may be treated. Here, too, the symptomatic relief ELAVIL often provides can be a valuable part of total treatment. As depressive symptoms are relieved, for example, patients may take advantage of the therapeutic activities offered and, even more important, may be discharged sooner and treated on an outpatient basis.



In the outpatient clinic. With follow-up treatment often necessary for three months or longer, ELAVIL is highly effective in maintaining relief, especially in patients who responded well to higher doses while hospitalized. As a result, these patients may continue to function in their daily activities.



In the mental hospital. Here where severely depressed patients present challenges for psychiatrist and staff alike, the usefulness of ELAVIL is increased by the 50-mg tablet that provides the higher doses often required and by the injectable form for more rapid effect.



In the community mental health center. A remarkable innovation in the field of modern psychiatry, this center offers a unique setting for treating patients with clinically significant depression. Here, too, ELAVIL often proves to be a true asset to the psychiatrist by providing highly effective symptomatic relief that can encourage communication, support the psychotherapeutic relationship, and accelerate the achievement of desired therapeutic goals.

ELAVIL should not be used during the acute recovery phase following myocardial infarction, in patients hypersensitive to it or in those who have received an MAOI within two weeks. Since suicide is a possibility in any depressive illness, patients should not have access to large quantities of the drug. Concurrent electroshock therapy may increase hazards associated with such therapy. Patients with cardiovascular disorders should be watched closely. The drug may impair mental or physical abilities required in hazardous tasks and may potentiate the effects of alcohol.

In many therapeutic settings—one proven antidepressant

TABLETS: 10 mg, 25 mg, and 50 mg INJECTION: 10 mg per ml

ELAVIL®

(AMITRIPTYLINE HCl | MSD)

For a brief summary of prescribing information, please see following page.

MSD
MERCK
SHARP
DOHME

addendum

ELAVIL®
(AMITRIPTYLINE HCl | MSD)
dosage forms for differing patient needs

25 mg (yellow)



This tablet may prove useful for most outpatients, who generally do well on 25 mg three times a day. This dosage may be increased to a total of 150 mg a day. Dosage increases are made preferably in the late afternoon or at bedtime. The sedative effect may be apparent before the antidepressant effect is noted. An adequate therapeutic effect may take as long as 30 days to develop.

50 mg (beige)



The 50-mg tablet may be indicated whenever higher dosages are required, as for example when increases are necessary in the late afternoon or bedtime doses. It may also be convenient for many hospitalized patients who may need 100 mg a day initially. In these patients, dosage may be increased gradually to 200 mg a day if necessary. A small number of hospitalized patients may need as much as 300 mg a day.

10 mg (blue)



Because lower doses are generally recommended for adolescents and elderly patients, the 10-mg tablets may be most serviceable. Ten mg three times a day with 20 mg at bedtime may be satisfactory in adolescent and elderly patients who do not tolerate higher dosages.

INJECTION
10 mg per ml



For patients unable or unwilling to take tablets, the injectable form may be suitable initially. The tablets should replace the injection as soon as possible. Initial intramuscular dosage is 20 to 30 mg (2 to 3 ml) four times a day. When Injection ELAVIL is administered intramuscularly, the effects may appear more rapidly than with oral administration.

Usage in Children: In view of the lack of experience in children, this drug is not recommended at the present time for patients under 12 years of age.

Contraindications: Known hypersensitivity. Should not be given concomitantly with a monoamine oxidase inhibitor or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred. When used to replace a monoamine oxidase inhibitor, initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with angle-closure glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child. Not recommended for patients under 12 years of age.

Precautions: Schizophrenic patients may develop increased symptoms of psychosis; patients with paranoid symptomatology may have an exaggeration of such symptoms; manic depressive patients may experience a shift to the manic phase. In these circumstances, the dose of amitriptyline HCl may be reduced or a major tranquilizer, such as perphenazine, may be administered concurrently.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Use cautiously in patients receiving large doses of ethchlorvynol, since transient delirium has been reported on concurrent administration. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards associated with such therapy; such treatment should be limited to patients for whom it is essential. When possible, discontinue the drug several days before elective surgery. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered. *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling, black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido, elevation and lowering of blood sugar levels. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice, alopecia. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

Overdosage: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-ml vials containing per ml: 10 mg amitriptyline HCl, 44 mg dextrose, 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives, and water for injection q.s. 1 ml.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

in the treatment of clinically significant depression

ELAVIL®
(AMITRIPTYLINE HCl | MSD)

too anxious to listen...
too depressed to respond



in mixed anxiety-depression*...

- Consider an agent that combats symptoms of coexisting anxiety and depression
- Consider an agent that acts rapidly
- Consider an agent that contains only *one* active ingredient
- Consider...

Mellaril®
(thioridazine)

TABLETS, 25 mg. thioridazine HCl, U.S.P.

***This drug has been evaluated as probably effective for this indication. See Brief Summary on following page.**

72-556 SANDOZ



too anxious to listen... too depressed to respond

Mellaril®
(thioridazine)

for moderate to severe mixed anxiety-depression*

***Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
Effective: The management of manifestations of psychotic disorders.
"Probably" effective: The relief of symptoms of neurotic depressive reaction; and control of moderate to severe agitation, hyperactivity, or aggressiveness in disturbed children.
"Possibly" effective: Alcohol withdrawal syndrome, intractable pain, psychoneuroses, senility.
Final classification of the less-than-effective indications requires further investigation.

Before prescribing or administering, see Sandoz literature for full product information. The following is a brief summary.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when the potential benefits exceed the possible risks to mother and fetus.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving), and increase dosage gradually. Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension since phenothiazines may induce a reversed epinephrine effect on occasion. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—ECG changes (see *Cardiovascular Effects* below). *Other*—A single case described as parotid swelling.

The following reactions have occurred with phenothiazines and should be considered: *Autonomic Reactions*—Miosis, obstipation, anorexia, paralytic ileus. *Cutaneous Reactions*—Erythema, exfoliative dermatitis, contact dermatitis. *Blood Dyscrasias*—Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia. *Allergic Reactions*—Fever, laryngeal edema, angioneurotic edema, asthma. *Hepatotoxicity*—Jaundice, biliary stasis. *Cardiovascular Effects*—Changes in terminal portion of electrocardiogram, including prolongation of Q-T interval, lowering and inversion of T-wave, and appearance of a wave tentatively identified as a bifid T or a wave have been observed with phenothiazines, including Mellaril (thioridazine); these appear to be reversible and due to altered repolarization, not myocardial damage. While there is no evidence of a causal relationship between these changes and significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients showing characteristic electrocardiographic changes while taking the drug. While proposed, periodic electrocardiograms are not regarded as predictive. Hypotension, rarely resulting in cardiac arrest. *Extrapyramidal Symptoms*—Akathisia, agitation, motor restlessness, dystonic reactions, trismus, torticollis, opisthotonus, oculogyric crises, tremor, muscular rigidity, and akinesia. *Persistent Tardive Dyskinesia*—Persistent and sometimes irreversible tardive dyskinesia, characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements) and sometimes of extremities may occur on long-term therapy or after discontinuation of therapy, the risk being greater in elderly patients on high-dose therapy, especially females; if symptoms appear, discontinue all antipsychotic agents. Syndrome may be masked if treatment is reinstituted, dosage increased, or antipsychotic agent is switched. Fine vermicular movements of tongue may be an early sign, and syndrome may not develop if medication is stopped at that time. *Endocrine Disturbances*—Menstrual irregularities, altered libido, gynecomastia, lactation, weight gain, edema, false positive pregnancy tests. *Urinary Disturbances*—Retention, incontinence. *Others*—Hyperpyrexia; behavioral effects suggestive of a paradoxical reaction, including excitement, bizarre dreams, aggravation of psychoses, and toxic confusional states; following long-term treatment, a peculiar skin-eye syndrome marked by progressive pigmentation of skin or conjunctiva and/or accompanied by discoloration of exposed sclera and cornea; stellate or irregular opacities of anterior lens and cornea.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936 72-556

SANDOZ

THE AMERICAN JOURNAL OF PSYCHIATRY

An Overview of Trends in Psychiatric Research: 1963–1972

BY H. KEITH H. BRODIE, M.D., AND MELVIN SABSHIN, M.D.

This overview presents a selected survey of psychiatric research trends in the United States from 1963 to 1972. The principal sources for the survey were articles published in the American Journal of Psychiatry *and the* Archives of General Psychiatry, *along with articles from the* Journal of Psychiatric Research *and abstracts submitted for presentation in the New Research sessions at APA's 1972 and 1973 annual meetings. The authors describe several interesting trends and developments that are reflected in the articles surveyed.*

THE PURPOSE OF THIS PAPER is to present a focused review of psychiatric research in the decade 1963–1972 as manifested by one particular type of objective data, namely papers published in selected psychiatric journals.

In conducting this review, a wide variety of options were available to us. Analyses could have been performed on the amount of money awarded or spent in given categories or content areas. Data could have been collected on the number of investigators involved in specific fields of psychiatric research. Departments of psychiatry could have been surveyed to determine their allocation and distribution of research personnel, funding, and space during the past decade. These data could then have been pooled to form a composite picture for the United States.

As we considered these options and conducted a literature search we were surprised to find that surveys of long-term psychiatric research trends have been rare. General review articles have been published, but most often they have involved either annual reviews (1) or broad overviews of selected subfields within psychiatry (2). To our knowledge there have been no surveys of overall psychiatric research trends in the United States for a particular decade. Furthermore, in publications dealing with overall psychiatric research for shorter periods of time, there has been very sparse utilization of objective data. By and large there has been a tendency to state impressions or conclusions without clarification of the methods that served as a basis for forming these opinions.

In this paper we have decided to present an overall survey of psychiatric research based on objectifiable data. We have elected to use periodical publications as our principal source since the articles they publish are the major product of research activity and lend themselves to breakdown by category. In addition, of course, their availability as part of the public domain makes it possible for others to verify or challenge our results and conclusions as well as our methods.

Our paper has been motivated to a large extent by the concern (3) that research activities in psychiatry have peaked and will begin to lose momentum during the coming decade. Since the research tradition in our field has been weak at best, a decline in research activity could be especially deleterious to psychiatry. The possibilities of a decline in research are reflected in table 1, which shows a 17 percent reduction in the number of research grants awarded by the National Institute of Mental Health over the past decade (4). In addition, although the total NIMH appropriation for research increased by about four percent per year between 1969 and 1972, the effect of inflation produced a net decrease in research support of five percent per year during this period.

Although we have not analyzed previous decades, we believe that research activity was beginning to show an increase during 1963–1972. Because of the general decline in research funding, however, the impact on psychiatry, with its weak research emphasis, may be considerable. On the more positive side, our role in developing a program of New Research sessions for the APA annual meeting and in judging papers submitted for presentation at the annual meetings for the past two years has given us access to a great deal of information on the status of psy-

This paper was written at the invitation of the Editor.

Dr. Brodie is Assistant Professor, Department of Psychiatry, and Program Director, General Clinical Research Center, Stanford University School of Medicine, Stanford, Calif. 94305. Dr. Sabshin is Professor, Department of Psychiatry, and Acting Dean, Abraham Lincoln School of Medicine of the University of Illinois, Chicago, Ill.

The authors gratefully acknowledge the kind assistance of Bettina MacAdoo, Marianne Petersen, Angela Williams, Victoria Williams, Heather Becker, Judith Howard, and David A. Hamburg, M.D.

TABLE 1
NIMH Research Grants Awarded in Fiscal Years 1963–1972

Fiscal Year	Number of Grants	Amount Awarded	Mean Award
1963	1,793	$49,811,007	$27,781
1964	1,634	52,912,048	32,382
1965	1,632	57,227,040	35,066
1966	1,663	61,278,318	36,848
1967	1,546	61,975,811	40,088
1968	1,478	66,930,612	45,285
1969	1,505	73,008,507	48,511
1970	1,471	69,559,073	47,287
1971	1,432	73,956,861	51,646
1972	1,497	82,484,176	55,100

chiatric research. This experience seemed rich enough to share with readers of this journal.

METHOD

Our most important methodological decision involved the selection of publications as a significant indicator of a decade's research trends. Once that decision was made it became necessary to choose specific publications for further analysis. After reviewing a number of psychiatric journals, we decided to select the *American Journal of Psychiatry* and the *Archives of General Psychiatry* as the major sources for our analyses. This decision was based on the fact that these two journals have general rather than specialized psychiatric content and are also the most widely circulated of the psychiatric journals. We were interested primarily in gaining a broad survey of psychiatric research as published in journals with the widest possible circulation. Arbitrary selectivity of this type may, of course, produce a number of significant artifacts. The exclusion of books, monographs, and other journals within the field of psychiatry and outside of it may cause skewing of the results and thus represents a basis for limiting our conclusions.

During the decade under investigation, a number of new journals[1] were introduced that might have drawn papers away from the *American Journal of Psychiatry* and the *Archives of General Psychiatry*. Most relevant to our study was the inauguration of the *Journal of Psychiatric Research* at the beginning of the decade surveyed in this paper. Since a specialized research journal in psychiatry appeared to be particularly significant to our data analysis, we conducted an additional investigation of papers published in the *Journal of Psychiatric Research* for purposes of comparison and as a check of reliability on the data obtained from the two major surveys.

During the decade 1963–1972, a total of 4,333 papers were published in the three journals surveyed. Each of these papers was reviewed and categorized as either a research or a nonresearch article. We focused this study on the research articles, which in our definition included hypothesis-generating papers (5) as well as hypothesis-testing presentations. In order to be classified as research articles, hypothesis-generating papers had to present sufficient use of appropriate statistical analyses as well as controlled studies to substantiate the hypothesis being proposed.

After making the research-nonresearch classification, we chose three major subdivisions to further categorize the research papers. We selected these subdivisions in the expectation that they would be useful in elucidating research trends over the decade and would thus contribute to the data analysis. Since no previous effort has been made to analyze research publications, the categories we selected are necessarily tentative and preliminary. The papers were categorized according to whether the primary focus of the study involved biological, psychological, or social variables. Since most etiological theories in psychiatry can be sorted into one of these three categories it appeared logical to use this classification as a starting point. Furthermore, analogous terminology has proven useful in categorizing psychiatric treatments (e.g., somatotherapeutic, psychotherapeutic, sociotherapeutic).

Having selected the biological, psychological, and social categorization at least in part because of its pertinence to etiology and treatment, the second set of categories was based on whether the papers were primarily reporting studies on etiology or on treatment. It became necessary to add a third category that we called "mechanisms" since a significant segment of psychiatric research is subsumed under variables intermediate between causality and therapeutic intervention. To some extent our mechanism category is a generic term covering a wide range of data; we presume that increasing clarity in our understanding of psychiatric disorders will lead to a more precise definition of variables of this type.

In making our decision as to whether a publication should be classified under etiology, treatment, or mechanism, we sometimes faced the problem of papers that included all three categories. Nevertheless, the great majority of the publications could be classified reliably within these rubrics. For example, studies on biological etiology included reports of the induction of paranoid psychoses as a result of amphetamine use and the development of hallucinations after taking LSD. Studies focusing on biological mechanisms included reports of electrical activity in the brain (contingent negative variation, average evoked response), the correlation between levels of catechol excretion and affective states, and EEG studies of sleep and dreaming. Reports of biological treatments included most of the articles on psychopharmacology and largely dealt with the relationship of treatment outcome to drug administration. Psychological etiology included sensory deprivation and isolation research and studies correlating childhood experience with adult psychopathology. The category of psychological mechanisms, which was broad, covered personality studies, psycho-

[1] *Psychotherapy: Therapy, Research, and Practice; Biological Psychiatry; Journal of Behavior Therapy and Experimental Psychiatry*; and *Behavior Therapy*, to mention only a few.

analytic research, and psychological testing methods. Psychological treatment reports included studies of the efficacy of psychotherapy and psychoanalysis, as well as treatment outcome in behavior therapy. Papers on social etiology were primarily studies of the effects of social factors (e.g., social class, ethnicity) on the development of mental illness. Social mechanism studies included reports of transcultural research on psychiatric symptoms. Papers on social treatment included reports of milieu therapy, community programs, and changes in delivery systems in the treatment process.

The 2,071 research papers were thus sorted by year in the three-by-three matrix described above. In addition to these nine mutually exclusive categories, the articles were also sorted into 21 topic areas on the basis of the principal topic covered in the paper. These 21 topics are the same ones that are used by the Program Committee to categorize papers submitted for presentation at APA's annual meetings.

In addition to the journal articles, all abstracts submitted to the Program Committee for inclusion in the New Research program in 1972 and 1973 were categorized as research or nonresearch. The research abstracts were then classified into the nine mutually exclusive categories and the 21 topic areas. Because these research reports will not be published until 1973 and 1974, they permitted us to make predictive projections in supporting our analysis of certain research trends.

RESULTS

During the decade 1963–1972, a total of 4,103 papers were published in the *American Journal of Psychiatry* and the *Archives of General Psychiatry*. Using the criteria described above, 1,885 or 46 percent of these were categorized as research articles. A gradual increase in the percentage of articles published in the two journals that met our criteria for research articles was noted. In 1963, 37 percent of the articles published in the two journals were classified as research articles; by 1967 this percentage had increased to 42 percent and in 1972 it had reached 48 percent. A reliability check was performed on this sorting procedure. Ten percent of the papers published during the decade were categorized as research or nonresearch papers by a research assistant who was blind to the initial sorting. The two ratings were in agreement in 88 percent of the cases; in general we can be 95 percent certain that the percentage of agreement between the two ratings lies between 85 percent and 91 percent in all cases.

The 1,885 papers that met our criteria for research papers were classified into the nine categories described above. The results are shown in figures 1 and 2 and figures 3, 4, and 5. A reliability check was also performed on this classification. A research assistant who was blind to the initial ratings reclassified a random sample of ten percent of the 4,103 articles published during the decade in the two journals under study. This research assistant agreed 64 percent of the time with the initial classification.

Over the ten-year period, 41 percent of the research articles published in the two journals focused on biological studies, 35 percent on psychological studies, and 24 percent on social studies. Only six percent of the research papers in this period focused primarily on etiology, 30 percent focused on treatment, and 64 percent focused on mechanisms.

Of the 350 abstracts submitted to the Program Committee for inclusion in the New Research program in 1972 and 1973, 80 percent were categorized as research abstracts. The results of their classification into the nine categories are presented in table 2.

Of the 230 articles published in the *Journal of Psychiatric Research* during the period 1963–1972, 81 percent met our criteria for research papers. No significant change in this percentage was noted over the ten years.

FIGURE 1

Distribution of Research Articles in the American Journal of Psychiatry *and* Archives of General Psychiatry *According to Biological, Psychological, or Social Factors*

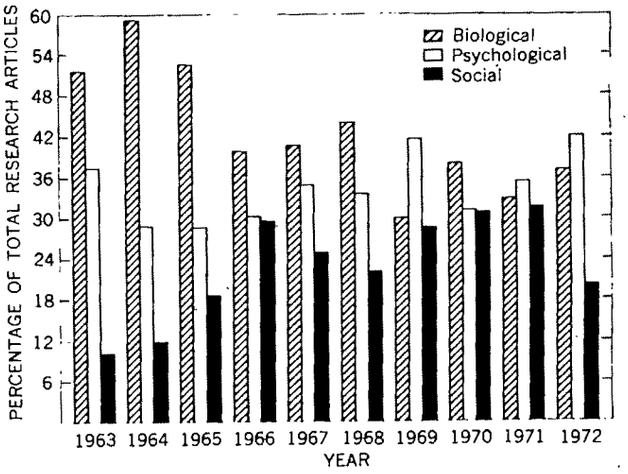
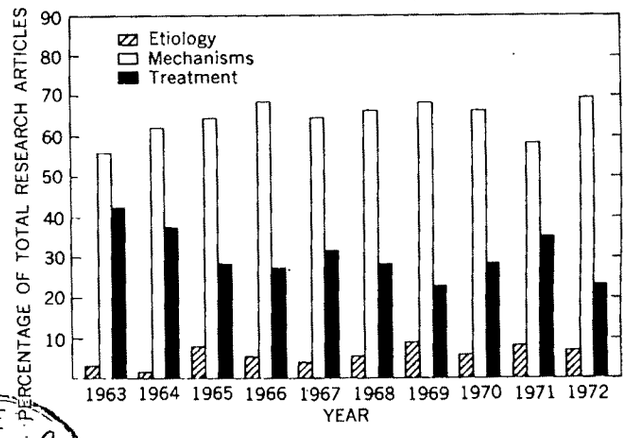


FIGURE 2

Distribution of Research Articles in the American Journal of Psychiatry *and* Archives of General Psychiatry *According to Focus on Etiology, Mechanisms, or Treatment*



UNIVERSITY OF [illegible] LIBRARY

All of these research papers and the research abstracts were sorted into the 21 topic areas. The results of this sorting are shown in table 3. A breakdown of the research articles appearing in the *American Journal of Psychiatry* and the *Archives of General Psychiatry* by topic for each of the years from 1963 to 1972 is presented in table 4. For purposes of comparison, we also sorted the nonresearch papers published in these two journals during the ten-year period into the 21 topic areas; these results are not shown.

DISCUSSION

The significant increase in the number of research articles published does not seem to reflect a leveling off or decrease in the federal funding of research through NIMH. Indeed there appears to have been an increase in the quantity and quality of research productivity as it is reflected in publications, although we have made no attempt to judge the quality of research articles. In this section we will attempt to identify some key papers that represent methodological breakthroughs, new research strategies, or emerging research themes.

We should note at the outset that we did not find the type of major research breakthrough that characterized the period after World War II, when psychopharmacologic and short-term psychotherapeutic interventions produced such a profound impact on psychiatric treatment. The decade reviewed in this study may have represented a steady consolidation of previous work, with the result that most new approaches have developed in response to practical needs, with the possible exception of behavior modification. Although some papers in the journals we surveyed came from other countries, this is predominantly a survey of research activity in the United States.

The number of biological papers published remained constant, but they represented a decreasing percentage of the research papers published during the decade. This may be accounted for in no small way by the increasing number of social research papers published during the decade. Several major research categories were not well represented in our review, probably because reports of studies in these fields appear in journals other than those we reviewed. This may explain the lack of research papers on psychoanalysis and psychosomatic medicine. Had we included a survey of *Psychosomatic Medicine*, the journal of the American Psychosomatic Society, we would have seen more research articles in this field.

Research abstracts and research articles published in the three journals surveyed were more frequently classified as relating to general physiological topics (see table 3) than to any other topic area during the decade. However, table 4 shows that the percentage of papers classified under this topic from the two major journals decreased by almost 50 percent during this period, as did papers on schizophrenia, while research articles on affective disease represented about ten to 15 percent of the articles published.

FIGURE 3
Distribution of Research Articles on Etiology

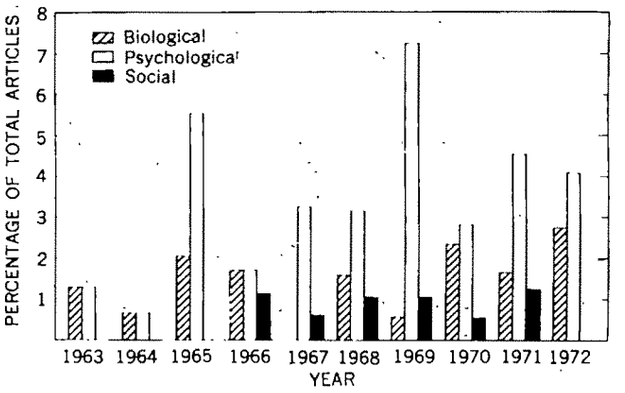


FIGURE 4
Distribution of Research Articles on Mechanisms

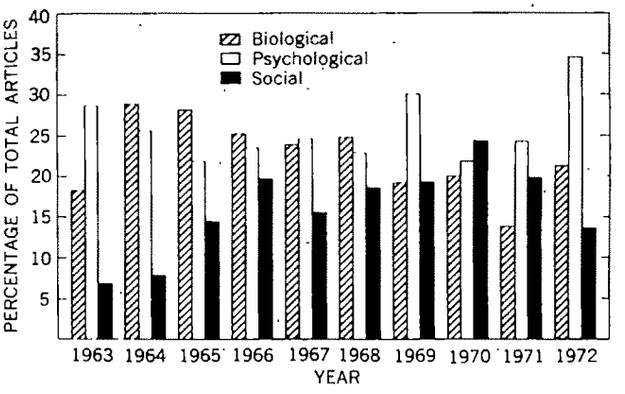
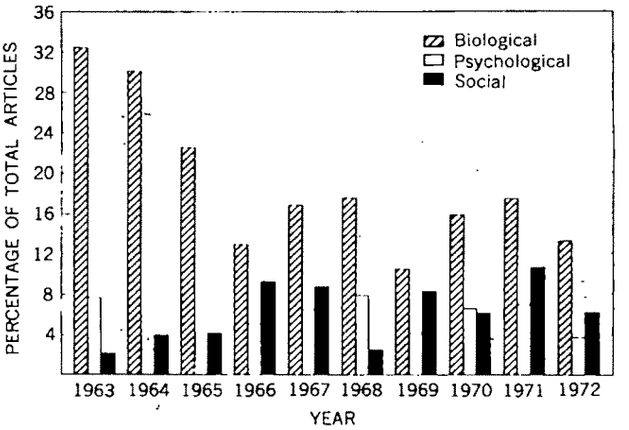


FIGURE 5
Distribution of Research Articles on Treatment



The marked increase in the percentage of research papers on drug abuse from four percent in 1963 to 16 percent in 1972 may well reflect an increase in funds available for research in this field. It is interesting to note that research articles on alcoholism did not show an increasing trend, although federal funding in this area was increased considerably (from $1.9 million in 1966 to $7.6 million in 1972 [6]). This may well be explained by the time lag between a surge in federal funding and production of research activity as measured by the number of research papers.

In order to facilitate a more coherent review of our results, we will present our discussion in three parts dealing specifically with biological research, psychological research, and social research.

Biological Research

During the decade prior to 1963, most of the psychopharmacologic agents currently in use today (with the exception of lithium) were developed, tested in clinical trials, and approved for general use by the Food and Drug Administration. In association with the introduction of these new drugs, there appeared numerous psychopharmacological research reports. The most dramatic trend in biological research from 1963 to 1972 was a decrease from 32 percent to 13 percent in the number of research papers on biological treatments. This trend was complemented by a small but significant increase in the number of research papers published on biological etiologies of mental illness.

There was a modest drop in the percentage of biological research articles published in the *American Journal of Psychiatry* and the *Archives of General Psychiatry* during the decade under study. This drop from 52 percent in 1963 to 37 percent in 1972 was complemented by a doubling in social research articles from 10 percent to 20 percent during the same decade. The percentage of research articles on psychological studies remained approximately

TABLE 2
Classification of Research Abstracts Submitted for the New Research Program in 1972 and 1973

Category	Biological		Psychological		Social		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Etiology	3	1	4	1	0	—	7	2
Mechanisms	100	36	51	18	52	19	203	73
Treatment	48	17	11	4	12	4	71	25
Total	151	54	66	23	64	23	281	100

TABLE 3
Classification by Topic Area of Research Articles Published During 1963–1972 and New Research Abstracts Submitted (1972–1973), in Percentages

Topic Area	Articles in *American Journal of Psychiatry* and *Archives of General Psychiatry* (N = 1,885)	Articles in *Journal of Psychiatric Research* (N = 186)	Research Abstracts Submitted for New Research Program (N = 281)
General physiological	14.4	28.6	16.2
Schizophrenia	14.1	17.2	11.2
Affective disease	11.8	15.9	9.0
Delivery of services	6.0	2.9	3.7
Drug abuse	5.4	3.4	11.5
Sociological/cross-cultural	4.7	0.6	5.4
Child psychiatry	4.5	1.4	7.2
General behavioral psychology	4.0	7.8	4.0
Electrophysiology	3.3	3.7	3.2
Sleep and dreams	3.1	4.1	3.6
Alcoholism	3.1	0.5	3.6
Psychoneuroses	3.0	0.5	3.3
Criminal/violent behavior	2.6	0.0	2.9
Family	2.0	0.5	0.7
Psychological testing	1.6	3.4	4.7
Organic brain syndrome	1.5	1.8	1.1
Personality	1.4	2.1	2.5
Sex	1.3	0.0	0.7
Adolescence	1.3	0.0	0.5
Geriatrics	1.3	0.4	0.7
Unclassifiable	9.5	5.8	4.6

TABLE 4
Classification by Topic Area of Research Papers Published in the American Journal of Psychiatry *and the* Archives of General Psychiatry *from 1963 to 1972, in Percentages*

Topic Area	1963 (N=154)	1964 (N=153)	1965 (N=146)	1966 (N=178)	1967 (N=185)	1968 (N=193)	1969 (N=193)	1970 (N=215)	1971 (N=247)	1972 (N=221)
General physiological	22.7	26.1	16.4	11.2	7.0	9.8	10.4	15.3	13.0	12.2
Schizophrenia	20.8	26.1	13.0	16.3	13.5	16.1	9.8	7.0	7.3	11.3
Affective disease	10.4	9.2	11.6	9.6	11.4	11.9	9.8	12.6	17.0	14.9
Delivery of services	5.2	7.2	4.8	8.4	5.4	3.6	7.3	7.4	6.1	4.5
Drug abuse	3.9	2.0	0.7	5.1	2.7	6.7	3.6	4.2	8.9	16.3
Sociological/cross-cultural	2.6	2.0	3.4	5.6	4.9	7.3	5.2	6.0	6.5	3.2
Child psychiatry	5.8	2.0	4.1	2.8	4.9	7.8	4.7	7.4	4.5	1.4
General behavioral psychology	0.6	2.0	2.1	5.1	4.9	2.6	9.8	5.6	2.8	4.1
Electrophysiology	5.2	3.3	6.2	1.7	3.8	5.7	0.5	4.7	0.4	1.4
Sleep and dreams	1.9	3.3	5.5	3.9	2.7	4.1	3.6	1.9	2.0	2.3
Alcoholism	1.9	1.3	1.4	2.8	3.8	2.1	6.7	2.8	5.7	2.3
Psychoneuroses	3.9	3.9	3.4	2.2	2.7	2.1	4.1	1.9	2.4	3.2
Criminal/violent behavior	1.9	2.6	3.4	1.7	2.2	1.0	4.7	3.7	2.0	2.7
Family	1.3	0.7	1.4	1.1	4.9	2.6	1.6	2.8	2.0	1.4
Psychological testing	0.6	0.0	4.1	1.1	2.2	1.0	1.6	1.4	0.8	2.7
Organic brain syndrome	0.6	2.0	0.7	2.8	2.7	3.1	1.0	0.9	0.8	0.9
Personality	0.6	2.6	2.7	1.1	3.2	1.6	1.6	0.9	0.0	0.9
Sex	0.6	0.7	0.7	0.0	1.1	2.6	2.6	1.9	0.8	2.3
Adolescence	1.3	0.7	2.7	2.8	1.6	0.5	0.5	1.9	0.8	0.4
Geriatrics	2.6	1.3	1.4	0.6	1.6	0.0	1.0	1.4	2.0	0.9
Unclassifiable	5.2	1.3	10.3	14.0	13.0	7.8	9.8	8.4	14.2	10.9

the same (38–42 percent) during this period.

Perhaps the most significant biological breakthrough of the decade occurred in the study of the biology of affective disease. Two papers (7, 8) published in 1965 were followed by a rapidly increasing number of reports during the subsequent seven years on the relationship between biogenic amines and affective illness. These papers represented a critical fusion of behavioral observations and biochemical data, the methodology for which was worked out in the early 1960s (9–11).

Of the small number—31—of papers published on biological etiologies of mental illness in the three journals reviewed for this study, 55 percent focused on genetic causes. More than half of these papers were published within the last two years of the decade. Most of the papers published on genetic factors in the etiology of mental illness focused either on genetic factors in affective disease (12, 13) or on a review of the genetic factors in schizophrenia by means of the analysis of twin studies (14). Several reports published during the decade concerned the endogenous synthesis of a hallucinogen in schizophrenic patients. One such line of inquiry is reported on elsewhere in this issue by Wyatt and associates (see pp. 1359–1361). A number of studies that compared environmental and genetic factors in the etiology of schizophrenia are briefly reviewed in the section of this discussion dealing with psychological research.

A review of the articles categorized as presenting data on biological mechanisms revealed that most could be classified according to whether they focused primarily on electrical activity of the brain or on biochemical activity of the brain as reflected in studies of blood, urine, or cerebrospinal fluid. Although studies of electrical activity decreased, biochemical studies of cerebrospinal fluid increased fivefold from the first half of the decade to the second. The number of studies published each year in the journals under review that related mental illness to blood or urinary components remained the same over the decade and accounted for approximately two-thirds of the studies categorized under biological mechanisms. Five percent of the articles published focused on components of cerebrospinal fluid as related to mental illness and the remaining 30 percent of the papers focused on electrical activity in the brain.

The most significant studies on biological treatments published during the decade concerned the efficacy of lithium carbonate in the treatment and prevention of recurrent affective disease. More than 90 percent of the 36 papers on lithium were published during the last half of the decade.

There was a gradual increase during the period under study in the number of papers on biological treatments that focused not only on drug efficacy but also on the differentiation of clinical populations on the basis of pharmacological response. In several papers therapeutic response to a psychopharmacological agent was interpreted as being indicative of an underlying biochemical defect, the nature of which was explained by the mechanism of the drug's action (7, 8).

Psychological Research

Among the papers on etiology, there were more studies on the psychological causes of mental illness than in the biological and social categories combined. Nevertheless,

these psychological papers on etiology accounted for only 3.25 percent of the total research articles over the decade. This suggests an emphasis on the identification and treatment of existing illnesses rather than on etiology and prevention.

In the search to discover the causes of maladaptive behaviors, the primary focus (57 percent of the papers) was on childhood as the critical period and the family as the critical arena of development. Much of this research involved forming a hypothesis, locating subjects with the appropriate diagnosis, and retrospectively analyzing early processes and events. In 1965 Gregory (15) published a study on delinquency in which data had been collected before the problem behavior arose. Other investigators have studied mental illness and ongoing patterns of interaction within the family, providing information valuable for the identification of children at high risk and situations that require therapeutic intervention (16, 17).

The use of twins in studies attempting to distinguish between nature and nurture in the etiology of schizophrenia was discussed by Stabeneau in 1968. He noted that many confounding variables in twin studies could be avoided by carefully establishing zygosity through serologic methods, adhering to definitive diagnostic criteria of schizophrenia, and studying monozygotic twins who were separately adopted away from their biological parents (18). Using methods that incorporated these criteria, Kety, Rosenthal, and associates reported data suggesting that there is a genetically determined vulnerability to schizophrenia that interacts with the environment in the development of the illness (19–21). The association of a familial or genetic factor with bipolar depression was reported in 1971 (22), but in general studies on the etiology of affective illnesses dealt less with familial variables and more with precipitating stress; unfavorable recent events, particularly personal loss, were often found to precede a depression (23–25).

Although in the last ten years 50 papers were published on the psychological mechanisms of the abuse of drugs and alcohol (most since 1968), no research was reported on the psychological etiology of these problems and only three papers considered their psychological treatment. Sixteen of the psychological research papers on the etiology of mental problems published between 1969 and 1972 were concerned with violence, while prior to 1969 papers on the causes of violence were totally absent from the literature.

One of the largest subgroups of papers on psychological mechanisms consisted of 35 papers on the diagnosis and classification of mental illness. A growing number dealt with the use of screening devices, self-scoring tests, and computers, possibly in response to the need to make more economical use of the therapist's time.

The predominant topic of psychological research papers from 1963 to 1972 was schizophrenia. The inability to identify a cluster of symptoms peculiar to schizophrenia affected all other areas of research on this widely studied affliction. The focus in the first part of the decade was on the process and content of the schizophrenic reaction. Later research tended to broaden the focus to investigate specific psychological operations, e.g., the use of conditioning techniques to alter the verbal behavior of schizophrenics (26). Fourteen of the 19 articles written on prognosis in the last ten years were concerned with schizophrenia. At the close of the decade Strauss and Carpenter (27) concluded that their findings "support the concept that outcome in schizophrenia is a complex phenomenon: a function of many factors, in which the diagnosis of schizophrenia is a predictor of only limited power."

There were only 15 psychological studies of child psychiatry and 26 on the family over the decade. Nor was the importance of family, group, and milieu therapies reflected by their sparse treatment—six out of 488 research articles on psychological mechanisms. The difficulties of the aged, a subject of recent social concern, was a topic for research in eight studies spread thinly over the ten years. The literature on the problems of women, however, revealed a definite rising trend; only four articles were published during the first half of the decade, while 11 appeared in the last five years.

An area in which sheer numbers are an impressive indication of research productivity was that of psychological responses to physical illness. There were 50 papers published on this topic, with a nearly 100 percent increase in the last five years. Although only eight papers were published on mania, seven of these appeared after 1969.

Sixteen percent (17 papers) of all the articles dealing with psychological treatment were concerned with behavior therapy, although only one discussed the possible mechanisms of this treatment modality. It may be that the enthusiasm for behavior therapy (as shown by the appearance in the last ten years of five major journals on behaviorism in the United States and Britain) had not yet reached such a point that its processes were studied, or it may be that such research was only published in the specialized journals, which we did not survey for this overview. Only three research articles reported on the applicability of this treatment for psychoses. Behavior therapy was found to have two major assets. First, it permitted the collection of quantitative data on behavioral changes from which the evaluation of effectiveness could be determined. Secondly, the techniques it presented for dealing with specific problems, such as reinforcement of imitative behavior in mute autistic children (28) or desensitization of phobias (29), seemed more amenable to acquisition and replication.

There were 107 research articles published in the past decade on the psychological aspects of treatment for mental disorders. Twenty of these articles pertained to individual psychotherapeutic treatment. When a specific disease was the focus of the article, nine times out of ten it was schizophrenia. In determining the variables of the treatment process that affected the outcome, attention seemed not to be on theoretical orientation but on the set of attitudes and expectations brought to the therapy session by patient and doctor (30–32). The skill of the psychiatrist appeared to depend more upon his personality and style of interaction than on his training. A recurrent theme stressed the importance of structuring the treat-

ment according to the needs of the patient. Autistic children, for example, reacted best to an organized environment (33), and women who were emotionally disturbed postpartum showed a better response when admitted to hospitals with their children (34).

Many papers documented the effectiveness of brief therapy and outpatient care for many types of illnesses. Three times as many papers were published on brief therapy and short-term hospitalization between 1967 and 1972 as during the first half of the decade. The results of all these studies supported the acceptability of this treatment, as long as adequate aftercare is provided following discharge. Several investigators documented the successful use of nonprofessional personnel in outpatient treatment (35). There were as many papers on group therapy as on individual psychotherapy, but those on the latter were spread evenly over the ten years, while studies on group therapy went from three during 1963–1966 to 17 during 1967–1972.

Social Research

One of the striking findings of this survey involves the paucity of papers on the social causes of psychiatric illness. Social psychiatric concepts had produced important formulations about etiology during the 1950s (36, 37), and by the beginning of the 1960s it appeared that we were on the verge of developing new constructs to account for social factors in psychopathology. Quite clearly, these new constructs have not emerged between 1963 and 1972 and this void may represent a significant commentary on the past decade. One of the most important questions about this issue concerns the emphasis on the development of practical programs during the 1960s rather than on theory building. Papers on the delivery of mental health services represented a large component of the papers we categorized as nonresearch. It is conceivable that these efforts siphoned off potential research on social etiology. Of course it is also conceivable that the larger number of papers on social mechanisms indicates a gradual move toward etiological formulations. It must also be added that social factors may still prove to be secondary or tertiary variables rather than primary etiological determinants.

To a significant degree, the increase in social research papers during the latter part of the decade reflected a large number of papers on mechanisms. For the ten-year period we classified 307 papers under the rubric of social mechanisms; the peak year was 1970, when 52 papers were so categorized.

By almost any criteria the papers on social mechanisms represent a heterogeneous group. They range from a number of transcultural analyses (38–41) to social-psychological studies of major national events during the decade, e.g., articles concerning demonstrators at national political conventions (42, 43). The epidemiology of mental illness continued to receive attention (44–47), as did alcoholism (48, 49), suicide (50–52), accidents (53, 54), forensic psychiatry (55, 56), violence (57,58), and the social readjustment of former patients (59–61). Toward the latter part of the decade there were relatively more papers on drug use and abuse (62–65), racism (66–68), problems among soldiers and veterans (69–71), and student mental health on the college campus (72–74). Newer concerns with ecology had not yet reached the psychiatric journals we surveyed, nor had the growing interest in sexism been reflected in the papers published.

The social mechanism papers when reviewed as a whole did not show evidence of striking new breakthroughs. Their large number and diverse character appear to indicate a significant attempt to come to grips with important social psychiatric issues, but the outcome of this massive and complex effort is still to be determined.

There were 122 research papers on social treatment published in the *American Journal of Psychiatry* and the *Archives of General Psychiatry* during the past decade. There were slightly more papers of this type toward the latter part of the ten-year period, with 1971 representing the peak year. In 1963 and 1964 the papers were concerned to a large extent with hospital psychiatry (75–79); these papers showed a sustained interest in the psychiatric hospital as a social system, which had been a dominant motif during the 1950s (80–83). It should be noted, however, that several of the 1963 papers involved general hospital psychiatry, reflecting a rapid increase in the number of such hospitals being used to provide a therapeutic setting.

By the latter part of the decade surveyed in this report, the focus on milieu therapy had receded significantly; in fact papers on hospital psychiatry declined in number and changed in theme. The relationship between the hospital and the community (84, 85) replaced the more specific investigation of the hospital's social structure, and alternatives to hospitalization emerged as a common subject (86–89).

Other themes that became more common in the latter part of the decade than they had been earlier included social system variables and drug abuse (90–93), newer types of group approaches (94, 95), and special types of urban psychiatric problems (96, 97). Among the nonresearch papers, these themes and others related to the delivery of mental health services were even more common and, of course, reflected the current interest in seeking a more equitable distribution of psychiatric services.

SUMMARY

The writing of this paper was stimulated by our interest in a survey of recent trends in psychiatric research and by concern about diminishing financial support for scholarly investigation in our field. In carrying out the survey we were impressed with how few previous analyses had been made of overall psychiatric research trends for periods of more than a year. Since we recognized the limited precedent for such a review, this paper has raised several methodological questions regarding long-term surveys of psychiatric research.

We selected articles published in the *American Journal*

of Psychiatry and the *Archives of General Psychiatry* as the major sources for our investigation. The 4,103 papers published in the two journals during the decade 1963–1972 were first sorted according to whether their primary concern was with biological, psychological, or social factors, and finally according to whether they focused on etiology, treatment, or intervening mechanisms. Both research and nonresearch papers were also classified into 21 topic areas.

Although the decade under study did not appear to produce a major research breakthrough, there were a number of interesting trends and emphases. We have tabulated these trends and discussed several of the significant developments and omissions that were reflected in the articles we selected for analysis.

REFERENCES

1. Brodie HKH, Rosenzweig M: Clinical psychiatry. Prog Neurol Psychiatry (in press)
2. Thompson LJ: Learning disabilities: an overview. Am J Psychiatry 130:393–399, 1973
3. Eisenberg L: Psychiatric intervention. Sci Am 229:116–127, 1973
4. Mental Health Research Grants for Fiscal Year 1972. Department of Health, Education, and Welfare Publication No 73-9082. Washington, DC, US Government Printing Office, 1973
5. Group for the Advancement of Psychiatry Research Committee: Some Observations on Controls in Psychiatric Research, GAP Report No 42. New York, GAP, 1959
6. Alcohol Research Task Force: Report to the Director of the National Institute of Mental Health. Washington, DC, US Government Printing Office (in press)
7. Bunney WE Jr, Davis JM: Norepinephrine in depressive reactions. Arch Gen Psychiatry 13:483–494, 1965
8. Schildkraut JJ: The catecholamine hypothesis of affective disorders: a review of supporting evidence. Am J Psychiatry 122:509–522, 1965
9. Bunney WE Jr, Hamburg DA: Methods for reliable longitudinal observation of behavior. Arch Gen Psychiatry 9:280–294, 1963
10. Gerbode F, Bowers W: Measurement of acid monoamine metabolites in human and animal cerebrospinal fluid. J Neurochem 15:1053–1055, 1960
11. Ashcroft GA, Sherman DF: Changes in the concentration of 5-OR indolyl compounds in cerebrospinal fluid and caudate nucleus. Br J Pharmacol 19:153–167, 1962
12. Winokur G, Ruangtrakool S: Genetic versus nongenetic affective disorder. Am J Psychiatry 123:703–705, 1966
13. Winokur G, Pitts FN Jr: Affective disorder, VI: a family history study of prevalences, sex differences, and possible genetic factors. J Psychiatr Res 3:113–123, 1965
14. Allen MG, Cohen S, Pollin W: Schizophrenia in veteran twins: a diagnostic review. Am J Psychiatry 128:939–945, 1972
15. Gregory I: Anterospective data following childhood loss of a parent. Arch Gen Psychiatry 13:99–109, 1965
16. Anthony EJ: A clinical evaluation of children with psychotic parents. Am J Psychiatry 126:177–184, 1969
17. Landau R, Harth P, Othnay N, et al: The influence of psychotic parents on their children's development. Am J Psychiatry 129:38–43, 1972
18. Stabenau JR: Heredity and environment in schizophrenia. Arch Gen Psychiatry 18:458–463, 1968
19. Kety SS, Rosenthal D, Wender PH, et al: Mental illness in the biological and adoptive families of adopted schizophrenics. Am J Psychiatry 128:302–306, 1971
20. Wender PH, Rosenthal D, Zahn TP, et al: The psychiatric adjustment of the adopting parents of schizophrenics. Am J Psychiatry 127:1013–1018, 1971
21. Rosenthal D, Wender PH, Kety SS, et al: The adopted-away offspring of schizophrenics. Am J Psychiatry 128:307–311, 1971
22. Brodie HKH, Leff MJ: Biopolar depression—a comparative study of patient characteristics. Am J Psychiatry 127:1086–1090, 1971
23. Paykel ES, Myers JK, Dienelt MN, et al: Life events and depression. Arch Gen Psychiatry 21:753–760, 1969
24. Beck JC, Worthen K: Precipitating stress, crisis theory, and hospitalization in schizophrenia and depression. Arch Gen Psychiatry 27:123–129, 1972
25. Cadoret RJ, Winokur G, Dorzab J, et al: Depressive disease: life events and onset of illness. Arch Gen Psychiatry 27:133–136, 1972
26. Pishkin V, Shurley JT: Verbal behavior conditionability of schizophrenics and normals within free operant paradigm. Arch Gen Psychiatry 20:167–173, 1969
27. Strauss JS, Carpenter WT Jr: The prediction of outcome in schizophrenia. Arch Gen Psychiatry 27:739–746, 1972
28. Hingtgen JN, Coulter SK, Churchill DW: Intensive reinforcement of imitative behavior in mute autistic children. Arch Gen Psychiatry 17:36–43, 1967
29. Hussain MZ: Desensitization and flooding (implosion) in treatment of phobias. Am J Psychiatry 127:1509–1514, 1971
30. Rabiner EL, Reiser MF, Barr HL, et al: Therapists' attitudes and patients' clinical status. Arch Gen Psychiatry 25:555–569, 1971
31. Belz BJ: Validation of the differential treatment success of "A" and "B" therapists with schizophrenic patients. Am J Psychiatry 119:883–884, 1963
32. Friedman HJ: Patient expectancy and symptom reduction. Arch Gen Psychiatry 8:61–67, 1963
33. Schopler E, Brehm SS, Kinsbourne M, et al: Effect of treatment structure on development in autistic children. Arch Gen Psychiatry 24:415–421, 1971
34. Van der Walde PH, Meeks D, Grunebaum HU, et al: Joint admission of mothers and children to a state hospital. Arch Gen Psychiatry 18:706–711, 1968
35. Mendel WM, Rapport S: Outpatient treatment for chronic schizophrenic patients. Arch Gen Psychiatry 8:190–196, 1963
36. Hollingshead AB, Redlich FC: Social Class and Mental Illness: A Community Study. New York, John Wiley & Sons, 1958
37. Dunham HW: The Culture of the State Mental Hospital. Detroit, Wayne State University Press, 1960
38. Brody EB: Recording cross-culturally useful psychiatric interview data: experience from Brazil. Am J Psychiatry 123:446–456, 1966
39. McCandless FD: Suicide and the communication of rage: a cross-cultural case study. Am J Psychiatry 125:197–205, 1968
40. Fabrega H Jr, Swartz JD, Wallace CA: Ethnic differences in psychopathology, I: clinical correlations under varying conditions. Arch Gen Psychiatry 19:218–226, 1968
41. Lachman JH: Swedish and American psychiatry: a comparative view. Am J Psychiatry 126:1777–1781, 1970
42. Miller PR: Social activists and social change: the Chicago demonstrators. Am J Psychiatry 126:1752–1759, 1970
43. Miller PR: Revolutionists among the Chicago demonstrators. Am J Psychiatry 127:752–758, 1970
44. Leighton DC, Harding JS, Macklin DB, et al: Psychiatric findings of the Stirling County study. Am J Psychiatry 119:1021–1026, 1963
45. McKegney FP: The incidence and characteristics of patients with conversion reactions, I: a general hospital consultation service sample. Am J Psychiatry 124:542–545, 1967
46. Silverman C: The epidemiology of depression: a review. Am J Psychiatry 124:883–891, 1968
47. Kramer M: Cross-national study of diagnosis of the mental disorders: origin of the problem. Am J Psychiatry 125 (April Suppl): 1–11, 1969
48. King LJ, Murphy GE, Robins LN, et al: Alcohol abuse: a crucial factor in the social problems of Negro men. Am J Psychiatry 125:1682–1690, 1969
49. Schuckit M, Pitts FN Jr, Reich T, et al: Alcoholism, I: two types of alcoholism in women. Arch Gen Psychiatry 20:301–306, 1969
50. Dorpat TL, Jackson JK, Ripley HS: Broken homes and attempted and completed suicide. Arch Gen Psychiatry 12:213–216, 1965
51. Tabachnick N, Litman RE, Osman O, et al: Comparative psychiatric study of accidental and suicidal death. Arch Gen Psychiatry 14:60–68, 1966
52. Bogard HM: Follow-up study of suicidal patients seen in emergency room consultation. Am J Psychiatry 126:1017–1020, 1970
53. Selzer ML, Weiss S: Alcoholism and traffic fatalities: study in futil-

ity. Am J Psychiatry 122:762–767, 1966
54. Selzer ML, Roger JE, Kern S: Fatal accidents: the role of psychopathology, social stress, and acute disturbance. Am J Psychiatry 124:1028–1036, 1968
55. McGarry AL, Bendt RH: Criminal vs. civil commitment of psychotic offenders: a seven-year follow-up. Am J Psychiatry 125:1387–1394, 1969
56. Guze SB, Goodwin DW, Crane JB: Criminality and psychiatric disorders. Arch Gen Psychiatry 20:583–591, 1969
57. West LJ: The psychobiology of racial violence. Arch Gen Psychiatry 16:645–651, 1967
58. Kinzel AF: Body-buffer zone in violent prisoners. Am J Psychiatry 127:59–64, 1970
59. Hall JC, Smith K, Shimkunas A: Employment problems of schizophrenic patients. Am J Psychiatry 123:536–540, 1966
60. Levenstein S, Klein DF, Pollack M: Follow-up study of formerly hospitalized voluntary psychiatric patients: the first two years. Am J Psychiatry 122:1102–1109, 1966
61. Zolik ES, Lantz EM, Sommers R: Hospital return rates and pre-release referrals. Arch Gen Psychiatry 18:712–717, 1968
62. Freedman DX: On the use and abuse of LSD. Arch Gen Psychiatry 18:330–347, 1968
63. Black S, Owens KL, Wolff RP: Patterns of drug use: a study of 5,482 subjects. Am J Psychiatry 127:420–423, 1970
64. Lipp MR, Benson SG, Taintor Z: Marijuana use by medical students. Am J Psychiatry 128:207–212, 1971
65. Lipp MR, Benson SG: Physician use of marijuana, alcohol, and tobacco. Am J Psychiatry 129:612–616, 1972
66. Comer JP: White racism: its root, form, and function. Am J Psychiatry 126:802–806, 1969
67. Sabshin M, Diesenhaus H, Wilkerson R: Dimensions of institutional racism in psychiatry. Am J Psychiatry 127:787–793, 1970
68. Jones BE, Lightfoot OB, Palmer D, et al: Problems of black psychiatric residents in white training institutions. Am J Psychiatry 127:798–803, 1970
69. Hayes FW: Military aeromedical evacuation and psychiatric patients during the Viet Nam war. Am J Psychiatry 126:658–666, 1969
70. Char J: Drug abuse in Viet Nam. Am J Psychiatry 129:463–465, 1972
71. Greden JF, Morgan DW: Patterns of drug use and attitudes toward treatment in a military population. Arch Gen Psychiatry 26:113–117, 1972
72. Reifler CB, Liptzin MB: Epidemiological studies of college mental health. Arch Gen Psychiatry 20:528–540, 1969
73. Robbins ES, Robbins L, Frosch WA, et al: College student drug use. Am J Psychiatry 126:1743–1751, 1970
74. Goode E: Drug use and sexual activity on a college campus. Am J Psychiatry 128:1272–1276, 1972
75. Morris HM, Appel KE, Procope JL: Psychiatric, community, and racial integration in a general hospital. Am J Psychiatry 119:1049–1054, 1963
76. Errera P, Wyshak G, Jarecki H: Psychiatric care in a general hospital emergency room. Arch Gen Psychiatry 9:105–112, 1963
77. Orlinsky N, Delia E: Rehospitalization of the schizophrenic patient. Arch Gen Psychiatry 10:47–54, 1964
78. Smith CM, McKerracher DG: The comprehensive psychiatric unit in the general hospital. Am J Psychiatry 121:52–57, 1964
79. Ullman LP, Gurel L: Size, staffing, and psychiatric hospital effectiveness. Arch Gen Psychiatry 11:360–367, 1964
80. Stanton AH, Schwartz MS: The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment. New York, Basic Books, 1954
81. Caudill WA: The Psychiatric Hospital as a Small Society. Cambridge, Mass, Harvard Press, 1958
82. Greenblatt M, York R, Brown EL: From Custodial to Therapeutic Patient Care in Mental Hospitals. New York, Russell Sage Foundation, 1955
83. Greenblatt M, Levinson DJ, Klerman GL: Mental Patients in Transition: Steps in Hospital-Community Rehabilitation. Springfield, Ill, Charles C Thomas, 1961
84. Fox RP, Graham MB, Gill MJ: A therapeutic revolving door. Arch Gen Psychiatry 26:179–181, 1972
85. Schwartz DA, Weiss AT, Miner JM: Community psychiatry and emergency service. Am J Psychiatry 129:710–714, 1972
86. Markson E, Kwoh A, Cumming J, et al: Alternatives to hospitalization for psychiatrically ill geriatric patients. Am J Psychiatry 127:1055–1062, 1971
87. Herz M, Endicott J, Spitzer RL, et al: Day versus inpatient hospitalization: a controlled study. Am J Psychiatry 127:1371–1382, 1971
88. Langsley DG, Machotka P, Flomenhaft K: Avoiding mental hospital admission: a follow-up study. Am J Psychiatry 127:1391–1394, 1971
89. Claghorn JL, Kinross-Wright J: Reduction in hospitalization of schizophrenics. Am J Psychiatry 128:344–347, 1971
90. Bowden CL, Langenauer BJ: Success and failure in the NARA addiction program. Am J Psychiatry 128:853–855, 1972
91. O'Malley JE, Anderson WH, Lazare A: Failure of outpatient treatment of drug abuse, I: heroin. Am J Psychiatry 128:865–867, 1972
92. Hughes PH, Senay EC, Parker R: The medical management of a heroin epidemic. Arch Gen Psychiatry 27:585–593, 1972
93. Perkins ME, Richman A: Prevalence of participation in methadone programs. Am J Psychiatry 129:447–450, 1972
94. Gendzel IB: Marathon group therapy and nonverbal methods. Am J Psychiatry 127:286–290, 1970
95. Jew CC, Clanon TL, Mattocks AL: The effectiveness of group psychotherapy in a correctional institution. Am J Psychiatry 129:602–605, 1972
96. Stubblebine JM, Decker JB: Are urban mental health centers worth it? Am J Psychiatry 127:908–912, 1971
97. Zimberg S, Lipscomb H, Davis EB: Sociopsychiatric treatment of alcoholism in an urban ghetto. Am J Psychiatry 127:1670–1674, 1971

A Comment on the "Amotivational Syndrome" in Marijuana Smokers

BY DAVID J. KUPFER, M.D., THOMAS DETRE, M.D., JACQUELINE KORAL, M.A., AND PETER FAJANS

Heavy smokers and light smokers of marijuana were compared for general psychological health, stable personality traits, changes in personality induced by long-term use of marijuana, effects of multiple drug use, and the "amotivational syndrome" that is said to result from heavy use of the drug. Results did not indicate any overall pattern of excess psychopathology for either group, although significant differences were found in levels of depression and organicity and in various personality traits. The findings suggest that heavy use of marijuana may be related to already existing depression and that impaired motivation may be a manifestation of depression rather than a consequence of frequent mairjuana use.

IT HAS OFTEN BEEN SUGGESTED that young adult marijuana users can be distinguished from nonusers on the basis of general psychological health and specific changes in personality induced by long-term, chronic use of the drug. Heavy, chronic users have often been thought to develop an "amotivational syndrome" typified by a diminution of ambition, productivity, and motivation (1). Although a number of surveys were conducted on the characteristics of users and nonusers several years ago (2, 3), today there are few college students who have not used marijuana, at least sporadically. Therefore, in order to investigate some of the largely unanswered questions about the use of marijuana by young adults, we decided to attempt to identify and compare personality traits and possible personality changes for light and heavy marijuana users, rather than compare chronic users with nonusers.

METHOD

A two-part survey on psychological health and personal drug use was distributed on a random basis to 115 male upperclassmen at a university in the East. Of these 115 subjects, 90 returned their forms fully completed; all indicated at least occasional use of marijuana. There were 44 subjects who reported smoking marijuana once a month to twice a week; they were classified as "light" or occasional users. The other 46 subjects reported using marijuana three or more times a week, thus qualifying as "heavy" users.

To test general psychological health we used the KDS scales,[1] three short, standardized psychiatric evaluation forms that are broad enough to elicit responses indicative of the disturbances of mood and cognition most frequently found in psychiatric practice. Each of the three scales (KDS-1, Psychological Symptom Form; KDS-2, Somatic Symptom Form; and KDS-3A, Personality Style) consists of a page of self-rating questions; this format is used to avoid administrative and interview biases (4, 5). Cluster scores for anxiety, depression, psychosis, organicity, and mania were obtained through the use of these tests (6).

The second part of the survey consisted of a 38-item questionnaire concerning a variety of psychological and sociological factors relating to the use of marijuana. In order to discriminate more precisely between the symptomatic behaviors and personality traits of light and heavy smokers, we examined the responses to individual items on this questionnaire as well as on the KDS scales.

RESULTS

The Group as a Whole

Perhaps the most striking finding concerning the group of light and heavy smokers as a whole was the relative "normalcy" of the subjects in personality and in behavioral adjustment. Table 1 shows the mean KDS cluster scores of psychiatric symptoms for our subjects and for 50 psychiatric patients at Yale-New Haven Hospital. In comparison to the scores of the psychiatric patients, the scores obtained by the college students are definitely at the lower end of the symptomatic continuum for anxiety, depression, and organicity, and are similar to what one would expect of the general population. The higher mania score of the students, and possibly the psychotic score, may reflect the fact that the college group was on the average approximately 13 years younger than the psychiatric group.

Heavy Versus Light Smokers

Responses to the drug-use questionnaire showed no

Dr. Kupfer is Director of Research and Associate Professor and Dr. Detre is Chairman and Professor, Department of Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, Pa. 15261. At the time of the study, Ms. Koral was Research Assistant and Mr. Fajans was a student at Yale University School of Medicine, New Haven, Conn.

[1] The KDS scales are being used for a number of clinical investigations. Information on the use of these forms is available from the first author, David J. Kupfer, M.D.

TABLE 1
KDS Cluster Scores for Combined Heavy and Light Marijuana Smokers and Psychiatric Patients at Yale-New Haven Hospital

Symptom	Marijuana Smokers (N = 90)	Psychiatric Patients (N = 50)	Difference
Anxiety	5.9 ± 0.6	11.4 ± 1.5	p < .001
Depression	13.0 ± 0.9	17.5 ± 1.7	p < .01
Psychosis	5.9 ± 0.5	5.1 ± 0.9	n.s.
Organicity	8.7 ± 0.7	12.0 ± 1.2	p < .01
Mania	11.1 ± 0.4	6.4 ± 0.6	p < .001

TABLE 2
KDS Cluster Scores for Heavy and Light Marijuana Smokers

Symptom	Heavy Smokers (N = 46)	Light Smokers (N = 44)	Difference
Anxiety	6.6 ± 0.9	5.2 ± 0.7	n.s.
Depression	15.1 ± 1.1	11.1 ± 1.1	p < .01
Psychosis	6.6 ± 0.7	5.2 ± 0.8	n.s.
Organicity	10.7 ± 0.8	7.0 ± 0.8	p < .001
Mania	10.6 ± 0.6	11.7 ± 0.5	n.s.

differences between the heavy and light user groups in many characteristics frequently associated with heavy marijuana use. There were no differences between the two groups in responses regarding work adjustment, grade-point average, or personality changes. However, the heavy marijuana users did differ from the light users in other areas. Heavy smokers were more likely to smoke when they felt happy ($p<.05$), depressed ($p<.01$), tense ($p<.001$), anxious ($p<.001$), bored ($p<.01$), angry ($p<.01$), or insecure ($p<.01$), and they stated that they often smoked in order to escape their problems ($p<.05$). In addition, heavy smokers were less likely than casual smokers to have a definite career goal ($p<.05$). Differences were also found in the circumstances under which the two groups smoked: heavy smokers more frequently smoked in groups ($p<.01$), in public ($p<.001$), and when they had a cold ($p<.001$), and were more likely to share a joint with others who had colds ($p<.001$).

On the KDS scales, however, the heavy smokers showed significantly higher scores for depression and organicity than those of our group of psychiatric patients, although they were significantly lower for anxiety (see table 2).

Table 3 gives an item-by-item analysis of significant KDS data for the two groups of smokers. The psychological symptom profile indicates that heavy smokers experienced a decrease in sharpness of memory and energy level and had difficulty expressing their thoughts. They also reported having more strange experiences. On the somatic symptom scale the heavy smokers again reported poor memory and also slurred speech, a rapid or pounding heartbeat, and an increased appetite. The results for the personality style scale, which measures stable personality traits, reveal that heavy smokers got tired easily, got anxious when they had to ask someone for a favor, and found it difficult to get close to people.

The only item characteristic of light smokers was a tendency to be late for appointments more frequently.

Hallucinogen Users Versus Hallucinogen Nonusers

Since marijuana smokers frequently use other drugs, we asked the students whether they had ever used hallucinogens and compared the 66 subjects who had used hallucinogens with the 24 who had not.

Hallucinogen users were in general older than nonusers ($p<.05$; average of 21.1 versus 20.5 years old) and had smoked marijuana longer ($p<.01$; average of 3.7 versus 2.8 years). Since the heavy marijuana smokers were more likely to have used hallucinogens than were the light smokers ($p<.05$), it is not surprising that most of the personality factors differentiating heavy from light marijuana smokers—without regard to use of hallucinogens—also differentiated subjects who had used hallucinogens from subjects who had not.

Although hallucinogen users as a group claimed that mood made no difference in their deciding when to smoke marijuana ($p<.05$), questionnaire responses showed that they were more likely to smoke if they were depressed ($p<.05$), tense ($p<.05$), anxious ($p<.05$), angry ($p<.05$), or insecure ($p<.01$). They stated that they felt more psychologically dependent on marijuana than on hallucinogens ($p<.05$) and thought that their use of it had influenced their personality ($p<.05$). Hallucinogen users were also more likely than nonusers to smoke marijuana in public ($p<.05$), to smoke with a cold ($p<.05$), and to share a joint with others who had colds ($p<.05$). The

TABLE 3
Comparison of Heavy and Light Marijuana Smokers, in Percentages

KDS Item	Heavy Smokers (N = 46)	Light Smokers (N = 44)	Difference
Psychological symptoms			
Strange experiences	57	27	p < .01
Loss of energy	41	18	p < .05
Difficulty expressing thoughts	39	18	p < .05
Memory not as sharp	48	25	p < .05
Somatic symptoms			
Poor memory	39	9	p < .01
Slurred speech	20	2	p < .01
Rapid or pounding heartbeat	13	0	p < .05
Increased appetite	26	7	p < .05
Personality style			
Late for appointments	26	48	p < .05
Anxious when asking a favor	61	25	p < .01
Tired and exhausted easily	20	5	p < .05
Difficulty getting close to people	48	16	p < .01

TABLE 4
Comparison of Heavy and Light Marijuana Smokers Who Were Hallucinogen Users

KDS Item	Heavy Smokers (N = 37)	Light Smokers (N = 29)	Difference
Psychological symptoms			
Noises seem louder	3	17	$p < .05$
Feel like talking with people	38	66	$p < .05$
Difficulty expressing thoughts	35	14	$p < .05$
Somatic symptoms			
Increased appetite	24	3	$p < .05$
Personality style			
Loss of temper	38	14	$p < .05$
Anxious when asking a favor	65	21	$p < .001$
Tired and exhausted easily	19	0	$p < .01$
Difficulty getting close to people	51	21	$p < .01$

group that had not used hallucinogens indicated a greater preference for undertaking the role of leader in a group situation ($p<.01$) and were more likely to enjoy intellectually oriented pursuits ($p<.05$).

KDS cluster scores showed that the hallucinogen users also tended to have higher organicity scores ($p<.05$), but there was no significant difference between the two groups in depression scores. Nonusers of hallucinogens showed higher scores for mania ($p<.05$).

In order to further explore the impact of hallucinogens on personality and the interaction of hallucinogen and marijuana use on psychiatric symptoms and personality traits, we examined the responses of heavy and light marijuana smokers who had used hallucinogens for individual KDS items. As shown in table 4, heavy marijuana smokers who used hallucinogens had more trouble expressing their thoughts, had an increased appetite, felt less like talking to people, and were less likely to think noises were getting louder. On the scale for lifelong personality traits, these subjects reported becoming tired more easily, getting anxious when they had to ask someone for a favor, finding it difficult to get close to people, and losing their temper when they did not get their own way.

Items on the drug questionnaire that significantly differentiated heavy from light marijuana-smoking hallucinogen users were similar to our findings differentiating heavy from light marijuana users in general.

Motivated Versus Amotivational Subjects

In the last part of our study we investigated the "amotivational syndrome" that has been reported for heavy marijuana users. First, we compared the KDS cluster scores for the 51 subjects who reported experiencing a decrease in ambition, motivation-productivity, or the ability to concentrate and those for the 39 subjects who had not noticed such a decrease. The amotivational group had higher scores for anxiety ($p<.05$), depression ($p<.001$), and organicity ($p<.001$), and a lower score for mania ($p<.05$).

On individual KDS items a variety of significant differences between the two groups were noted. Amotivational subjects reported less energy, slowed-down thinking, difficulty in making decisions, a decrease in sharpness of memory, and less desire to talk to people (see table 5). Significant somatic symptoms for this group included drowsiness, poor memory, blurred vision, lack of energy, slurred speech, and increased appetite.

Responses to items regarding personality style indicated that these subjects, more frequently than motivated subjects, asked themselves: "Have I done the right thing?" On the other hand, motivated subjects more frequently answered the following questions affirmatively than did amotivational subjects: "Do you stop and think before doing the smallest thing?" and "Do you tend to lose your temper when you don't get your own way?"

Even though heavy marijuana users did not report amotivational traits any more frequently than light users did ($\chi^2 = 1.98$, n.s.), we attempted to refine our analysis of amotivation by dividing our subjects into four groups: light smoking amotivational subjects (N = 17); heavy smoking amotivational subjects (N = 34); light smoking motivated subjects (N = 27); and heavy smoking motivated subjects (N = 12).

There were no significant differences between the two amotivational groups on KDS cluster scores for depression and organicity. But when amotivation was used as the discriminant, significant differences emerged in depression and organicity scores. The light smokers who were amotivational had significantly higher scores for depression ($p<.001$) and organicity ($p<.001$) than did the light smokers who were motivated. Similarly, the amotivational heavy smokers scored higher on depression ($p<.001$) and organicity ($p<.01$) than did the motivated heavy smokers.

TABLE 5
Comparison of Amotivational and Motivated Groups, in Percentages

KDS Item	Amotivational Group (N = 51)	Motivated Group (N = 39)	Difference
Psychological symptoms			
Loss of energy	43	10	$p < .001$
Slowed-down thinking	35	8	$p < .01$
Difficulty making decisions	35	15	$p < .05$
Memory not as sharp	53	10	$p < .001$
Feel like talking with people	43	67	$p < .05$
Somatic symptoms			
Drowsiness	51	26	$p < .05$
Poor memory	43	5	$p < .001$
Blurred vision	22	5	$p < .05$
Lack of energy	41	13	$p < .01$
Slurred speech	22	3	$p < .01$
Increased appetite	27	5	$p < .01$
Personality style			
Have I done the right thing	76	49	$p < .01$
Think before doing smallest thing	10	31	$p < .01$
Lose temper easily	20	41	$p < .05$

DISCUSSION

The results of our investigation indicate that the group as a whole appears "normal" in the sense that its scores indicative of psychopathology are much lower than would be expected in psychiatric patients. The overall pattern is therefore not indicative of psychopathology associated with the use of marijuana, even in subjects who smoke daily. However, the data do discriminate between heavy and light smokers, especially on items measuring depression and organicity. Indeed, the scores of the heavy smokers on the depression and organicity scales were almost as high as those of a group of psychiatric patients. In addition, responses to items measuring stable personality traits revealed differences between heavy and light smokers in levels of anxiety, exhaustion, and difficulty in getting close to people.

These observations agree with those of Mirin and associates (7), who found greater anxiety and depression among men who reported heavy use of marijuana. These heavy smokers also experienced difficulty in getting close to women and often reported fair or poor heterosexual development. Similar findings have been reported by Crumpton and Brill (8), using MMPI scales, and by Berman and Benierakis (2), who studied the California Personality Inventory scores of high school students who later used marijuana regularly. Their scores revealed a lower sense of well-being, higher anxiety, and lower levels of socialization and self-control than were found among their nonsmoking peers. Berman and other investigators have found that heavy marijuana smokers score lowest on scales measuring obedience to convention and achievement through conformance and sociability (2, 9).

The results of our study, however, do not permit us to conclude that marijuana use is responsible for the psychiatric symptoms and personality traits our subjects reported, since the subjects were instructed to respond to personality survey items on the basis of experiencing the trait for "most of your life." Such traits are probably lifelong personality habits and may even be related to one's motivation for becoming a heavy marijuana user.

The existence of multiple drug users compounds the problem of discriminating between the effects of heavy and casual use of marijuana. Several investigators have reported a positive relationship between marijuana smoking and the tendency to use other drugs (9, 10). Harmatz and associates (11) found that a stepwise increase in psychiatric symptoms accompanied increased use of drugs, with nonusers having the fewest symptoms, multiple drug users having the most, and marijuana-only users being somewhere in between. When we compared our subjects who had used hallucinogens on the basis of the frequency with which they used marijuana, we found that the differences between heavy and light smokers remained about the same regardless of the use of hallucinogens.

The most interesting findings from our study concern the amotivational syndrome in heavy smokers of marijuana. McGlothlin and West (1) have described this phenomenon as consisting in its extreme form of a number of subtle personality changes that develop slowly over the course of time. These changes include diminished drive, lessened ambition, decreased motivation, apathy, shortened attention span, and distractibility; in short, the development of a more passive, inward-turning personality. Studies by other investigators have lent support to this hypothesis. Shean and Fechtmann (12) reported a significantly lower mean "purpose in life" score for marijuana users than for non-drug users, indicating a more passive, experiential life-style for the former group. Halikas, Goodwin, and Guze (13), using a checklist of 105 potential marijuana effects, found that 16 percent of the regular users they studied reported usually experiencing at least one unpleasant effect from marijuana, such as reduced self-confidence, indifference or apathy, poor memory, depression, or anxiety.

In contrast, our data suggest that the amotivational personality type is not dependent on the frequency of marijuana use, since high depression and organicity scores were found for all amotivational marijuana smokers, both heavy and light. Of course, we do not know what percentage of marijuana nonusers in this student population would show similar characteristics. It is possible that these symptoms indicate mild depressive syndromes or the prodromal stages of depression in college students. Only large-scale studies that include nonusers and that can maintain long-term follow-up will be able to determine whether the use of marijuana is responsible for these symptoms, exaggerates their occurrence as a constellation, or bears some other relationship to them.

REFERENCES

1. McGlothlin WH, West LJ: The marijuana problem: an overview. Am J Psychiatry 125:370–378, 1968
2. Berman G, Benierakis C: Characteristics of student marijuana users. Can Psychiatr Assoc J 17(suppl 2):37–40, 1972
3. Brill NQ, Crumpton E, Grayson H: Personality factors in marijuana use. Arch Gen Psychiatry 24:163–165, 1970
4. Kupfer D, Detre TP: Development and application of the KDS-I in inpatient and outpatient settings. Psychol Rep 29:607–617, 1971
5. Kupfer D, Detre TP: Once more—on the extraordinary side effects of drugs. Clin Pharmacol Ther 12:575–582, 1971
6. Kupfer D, Detre TP, Amdur M: KDS scale for symptom discrimination. Psychol Rep 30:915–919, 1972
7. Mirin SM, Shapiro LM, Meyer RE, et al: Casual versus heavy use of marijuana: a redefinition of the marijuana problem. Am J Psychiatry 127:1134–1140, 1971
8. Crumpton E, Brill NQ: Personality factors associated with frequency of marijuana use. Calif Med 115:11–15, 1971
9. Hogan R, Mankin D, Conway J, et al: Personality correlates of undergraduate marijuana use. J Consult Clin Psychol 35:58–63, 1970
10. McAree CP, Steffenhagen RA, Zheutlin LS: Personality factors in college drug use. Int J Soc Psychiatry 15:102–106, 1969
11. Harmatz R, Shader R, Salzman C: Marijuana users and non-users: personality test differences. Arch Gen Psychiatry 26:108–112, 1972
12. Shean GD, Fechtmann F: Purpose in life scores of student marijuana users. J Clin Psychol 27:112–113, 1971
13. Halikas J, Goodwin D, Guze S: Marijuana effects: a survey of regular users. JAMA 217:692–694, 1971

Emergency Psychiatric Hospitalization via Court Order: A Critique

BY JACK ZUSMAN, M.D., AND SUSAN SHAFFER

In order to provide emergency psychiatric hospitalization for disturbed persons who refuse treatment while at the same time protecting their civil liberties, New York State has instituted a system of court-ordered psychiatric examinations. The authors contend that this system is incapable of responding quickly in an emergency, lacks flexibility in providing alternative sources of treatment, and tends to diffuse decision making, so that no one official feels responsible for the patient. In addition they have found that although the court-ordered system is intended to protect civil liberties, the manner in which it is carried out demeans the supposedly ill person, risks disruption of his family and social relationships, and forces the police to treat him like a criminal.

POLICE AND MAGISTRATES must frequently deal with people whose behavior is seriously disturbed and clearly suggests mental illness and for whom there is no adequate means of help available other than psychiatric hospitalization—yet who refuse to be hospitalized. Many such disordered people have broken no law but either seem unable to care for themselves adequately or seem to be dangerous to themselves or to the people around them.[1]

Psychiatrists working in public agencies face a similar problem. When a seriously ill person is brought for help the only way the psychiatrist can help him may be through hospitalization. He needs a mechanism that will ensure hospital treatment for the patient who refuses admission.

On the other hand, the concept of involuntary hospitalization may disturb civil libertarians, who are concerned that there may be an unjustified loss of freedom on the part of people who have committed no crime and who, although strange, may be quite harmless or may even be effective and self-supporting participants in the social system. Civil libertarians are well aware of the limited ability of psychiatrists to predict future dangerousness and of their inclination to incarcerate a person when there is any doubt about the safety of his conduct (1). Civil libertarians are also aware of this country's long history of inadequate and even harmful treatment methods in state mental hospitals (where the unwilling are traditionally sent) and of the past tendency of psychiatrists to tolerate such a situation for their patients. Civil libertarians are therefore reluctant to have someone sent unwillingly to a mental hospital without proof beyond a doubt that hospitalization is needed.

At times, the varying interests involved in a psychiatric emergency are so diverse and incompatible that no satisfactory resolution can be found. For example, in an effort to provide emergency involuntary psychiatric hospitalization for mentally disturbed people while at the same time protecting their civil liberties, the state of New York has developed a system that is often too slow to respond to emergencies, provides no expert evaluation of the need for involuntary hospitalization before taking the person into custody, and often leads to degradation, public disgrace, and the rupture of important personal relationships for the person in custody as well as for those close to him.

THE COURT ORDER SYSTEM

In 1964 the state legislature passed a major revision to the New York Mental Hygiene Law. The revised law was hailed as a promising vehicle "to eradicate many of the evils of pre-existing statutes and make many laudable innovations" (2). One provision of this law, carried over in part from previous laws and similar to provisions of laws in many other states (3, 4), authorizes magistrates to order the emergency psychiatric hospitalization of unwilling persons.

Section 78.4 of the Mental Hygiene Law states:[2]

> Whenever any magistrate is informed that a person is apparently mentally ill, the magistrate may issue a warrant directing that such person be brought before the court out of which said warrant is issued. If when said person is brought before the court it appears to the magistrate that such person is or may be mentally ill, the magistrate shall issue a civil order directing his removal to any hospital specified in Subdivision 1 of this section, willing to receive such person for determination by the director of such hospital whether such person should be retained therein pursuant to this section (5).

This section of the state law attempts to resolve any

Dr. Zusman is Professor of Psychiatry, State University of New York at Buffalo, E.J. Meyer Memorial Hospital, 462 Grider St., Buffalo, N.Y. 14215. At the time this paper was written Ms. Shaffer was a Summer Fellow, Division of Community Psychiatry, State University of New York at Buffalo.

The authors wish to express their appreciation to Karen B. Miller and William A. Carnahan for assisting and advising in the preparation of this paper.

[1] Although there is no certain way to predict that a person will be dangerous, in a number of cases even an intelligent layman can quite accurately predict a person's behavior in the near future. Certainly prediction could be improved still further by appropriate studies.

[2] Effective January 1, 1973 (following completion of this report), the Mental Hygiene Law was revised extensively, but the basic approach of the revised law remains the same.

conflicting interests by providing for judicial involvement in the earliest phases of the case for or against involuntary hospitalization of the person suspected of being mentally disturbed. This procedure affords some comfort to civil libertarians since the decision is not made by psychiatrists or family members alone. The use of warrants served by the police also permits the application of physical force when this is necessary in order to bring the person in for examination.

PROCEDURE

To determine the effectiveness of Section 78.4 in helping disturbed people against whom warrants were obtained in a large metropolitan area of New York State, the records of the Buffalo City Court, the Buffalo Police Department, and the E.J. Meyer Memorial Hospital (Erie County) Department of Psychiatry were searched. The period of January 1 through May 31, 1972, was chosen as being the most recent long-term segment that would be easily available for scrutiny.

Court and police records are public documents and therefore were easily accessible. Hospital records, however, are confidential and could not be examined. Instead, the hospital was given a list of names and provided aggregate data on them.

FINDINGS

Between January 1 and May 31, 1972, 89 warrants were issued by the Buffalo City Court under Section 78.4. This represents a rate of 214 warrants a year and 0.47 warrants per 100,000 persons a year. (In 1972 there were 2,288 admissions to the county hospital psychiatric unit.)

Of the 89 warrants issued in the period under study, 12 were later withdrawn (although—apparently in error—two people named on withdrawn warrants were taken into custody anyway). Of the remaining 77 warrants, 24 (31 percent) were not served during the period under study, presumably because the people named could not be located by the police (despite the fact that this is supposed to be an emergency procedure and that the person swearing out the warrant should be in close contact with the person named). This left 53 warrants that were actually served. Only two of these were served on the same day on which they were signed; three warrants were served as late as one to two months later. The mean time between signing the warrant and serving it was a little more than ten days. Two earlier warrants, one signed in 1970 and the other in 1971, were served during the period under study.

Of the 55 people apprehended (53 as a result of warrants signed during the period under study and two as a result of warrants signed previously), 15 (27 percent) were placed in a police headquarters lockup to await an appearance before the judge. Three of these people had a wait of from one and a half to two hours in the daytime, and the remaining 12 were kept overnight in the police lockup. (One of these people also had criminal charges pending against him.) This lockup is, of course, the same facility used to hold suspects in custody on criminal charges.

Of the 55 cases brought before the judge, eight (15 percent) were dismissed in court; these eight were released without being sent to the hospital or being seen by a psychiatrist. (Three of these eight people had been held in the lockup the previous night.)

During the period under study the county hospital examined 68 people brought there under Section 78.4 warrants (this included people brought from courts outside of the City of Buffalo). Of the group examined, 24 (35 percent) were admitted to the county hospital, and 16 others (24 percent) were sent with involuntary certification papers to Buffalo State Hospital, where presumably many of them were admitted, since the state hospital makes its own independent evaluation of need for hospitalization. Fifteen people (22 percent) were given appointments to the county hospital outpatient department, but no mechanism was provided for ensuring follow-up.

Two people were returned home and referred for later screening for possible admission to the state hospital as geriatric patients. This meant that they were to be examined at home by a state hospital representative sometime during the next few days. If accepted for admission, they would be brought back to the county hospital, where two additional physicians would carry out another examination, sign certification papers, and arrange for their transportation to the state hospital. These people would receive at least five separate psychiatric examinations before arriving at the hospital several weeks after the process began. Two of the people in custody apparently left the county hospital without permission before being examined. One person was given medication and sent home and eight others were sent home without any treatment or follow-up.

Thus, of the 68 patients actually sent to the hospital, slightly more than half were admitted and the remainder were left essentially on their own to carry out whatever follow-up was recommended.

Sixty percent of the 53 subjects in the study were male, and 33 percent were nonwhite. (The population of Buffalo is 21.5 percent nonwhite.) No data were available regarding socioeconomic status. However, most subjects were from central-city census tracts, and almost none were from the city's upper-middle-class or upper-class residential areas.

CASE REPORTS

During the course of the study it was possible to obtain personal interviews with a small number of subjects. These respondents were selected only for their accessibility to the researchers for an interview. To provide a profile of individual cases, two are reported here.

Case 1. A 28-year-old single white woman was accused by

her mother of "being in a depressed state of mind and of continually using obscene language." According to the mother, who was interviewed, the woman's hostile attitude had been of great concern to her family for many years. She had once been hospitalized for mental illness but had been released for outpatient care. The family had recently contacted the county hospital for help and had been told that the hospital was unable to send anyone to see the woman at home. They suggested that a warrant be obtained. The mother applied for the warrant and it was served on the same day.

The woman was brought to court by the police and had to wait two and a half hours before appearing before the judge. She requested the assistance of the public defender, who pointed out to the judge that the family's complaint concerned an alleged family dispute—which according to law should be handled by the family court. The complaint was therefore dismissed, and the family was given the option of obtaining a warrant (not under Section 78.4) through the family court.

At this point the family had spent many hours attempting to obtain help, only to end up where they had started. They then went to the family court. When they learned how long it would take before they could get a hearing, they decided to drop the matter.

The woman in question now has an arrest record, feels increased hostility toward her family, and has not received any psychiatric help.

Case 2. A 46-year-old married white man appeared in court after a night in the police lockup. He was apprehended on the basis of a warrant sworn out by his wife, who alleged that he was mentally ill, refused to take prescribed medication, had terrible temper rages, and had once threatened suicide. The man stated that he had never been hospitalized for psychiatric reasons and that he held a full-time job. The question was raised at this point of whether his wife might be mentally ill, since she had had previous psychiatric treatment.

The man waited in court for two hours before appearing before the judge. After some persuasion he agreed to go voluntarily to the county hospital for psychiatric examination, yet was transported in handcuffs by uniformed sheriff's deputies. After a brief examination in the hospital he was released, with no follow-up indicated. He was then completely on his own to make his way back to the police station where his possessions had been kept and then go on to work. In the end he had spent many hours in custody, a night in jail, had lost time from work, had gotten an arrest record, and had received no help. There was no mechanism for investigating the problems that had led to the original complaint.

DEFICIENCIES OF THE WARRANT SYSTEM

Our examination of New York's emergency psychiatric intervention system has led us to believe that the use of a magistrate's warrant to obtain psychiatric examination is inadequate and often harmful. Although the system is designed to deal with emergencies while at the same time protecting the civil liberties of the people concerned, the warrant procedure is usually too slow to respond in an emergency and, although it superficially protects some aspects of civil liberties, the procedure seems likely to damage the allegedly disturbed person's self-image, reputation, and family relationships.

Two other major deficiencies in the warrant system are its lack of flexibility in providing alternatives for patient care (this has been noted by Wexler and associates in their study of hospital commitment in Arizona [3, p. 14]) and its diffusion of decision making, so that no one official feels responsible for the outcome of the case. And finally, a fundamental reason for the system's inadequacy is the availability of alternative means of providing for involuntary psychiatric examination, so that the warrant is used only for the most difficult and least clear-cut cases—which would cause trouble in any system.

Failure to Respond Rapidly

The warrant is not likely to be useful in an emergency because the numerous administrative levels, independent decision makers, and communication gaps make a rapid response impossible. If a mentally ill person is in a crisis state at the time the application is made for a warrant, the crisis will almost certainly have been resolved by some means (perhaps for the worse) by the time the warrant is served. (This time-lag problem may not apply in suburban areas. In several towns we found a delay of no more than several hours between signing and service of warrants; yet in these towns warrants were infrequently used.)

Disruption of Individual Rights

The protection of individual civil liberties has many aspects. Certainly one of them is protection from unwarranted involuntary psychiatric examination and hospitalization. However, other individual rights include protection from unnecessary police custody, from hours of detention in the company of suspects arrested on criminal charges, and from involuntary transportation across the city to the hospital only to be released from it without funds, without a means of return transportation, and with personal possessions locked up in a police station that may be far from both the hospital and home. Only slightly more than half of those taken into custody by the police were actually admitted to the hospital, and probably at least a few of those admitted were later found not to need hospitalization. Yet every one was apprehended without prior notice by the police, taken through the streets under guard (and frequently in handcuffs) to the lockup or court, and treated in almost every respect as an accused criminal.

Our impression is that in many cases the person who was apprehended never really understood his status in the situation, nor were the police in a position to explain it to him. Even the rare policeman who understood all the fine points of the law would not have information available on the particular case, since the warrant and accompanying documents contain only vague legalistic descriptions of the behavior and problems that led to the "arrest."

Diffusion of Responsibility

In the first phase of the process, the magistrate is required either to sign the warrant or to refuse to sign. He cannot require any intermediate measures to be taken, such as directing the person in question to appear for an appointment at a clinic or sending a probation officer to

investigate the need for intervention. At the next stage, when the warrant is served, the police are in no position to negotiate with an unwilling person either to coax him into coming for an examination voluntarily or to allow him time to make up his mind. They are busy, under pressure to finish their task rapidly, and probably unhappy with their assignment. They are likely to devote little effort to avoiding a confrontation and often can do no more than offer the person the choice of walking out by himself or being carried out.

If when the allegedly disturbed person appears before the magistrate the magistrate feels psychiatric examination is necessary, he will direct that the person be taken to the hospital. In such an event, even if the person is willing to go voluntarily, the police are likely for their own protection to treat him as potentially dangerous and to transport him in handcuffs in a marked police car. (This occurred in one of the cases we studied.) When the magistrate is not certain of the need for a psychiatric examination or when he would like it to occur on a voluntary basis, he does not have the time to interrupt his busy court schedule for a discussion with the subject and his family. Furthermore, the magistrate would have no means of ascertaining whether a promised psychiatric examination took place.

At the final stage of the process, in the county hospital, if the examining physician feels that treatment is definitely needed but not on an inpatient basis, he has no way of arranging for outpatient care. He can offer to set up an outpatient appointment, but once the patient is released from legal custody the hospital has no power to make him return for an appointment.

In emergency intervention systems that base emergency psychiatric hospitalization on the decision of a single physician (or in some cases two physicians), it is clear to all concerned (including the physicians) where the responsibility for hospitalization rests and who will have to undertake a defense if there are accusations of medical malpractice or false imprisonment. But even beyond these gross measures to ensure that someone is responsible for careful decision making and proper care, such a system offers the protection of the doctor-patient relationship, with its centuries-old tradition of care and the repeated emphasis during medical training on the physician's personal responsibility for his patient.

In the warrant system, on the other hand, no single individual makes a decision to hospitalize and no single individual is likely to see himself as responsible for the outcome or even as having the power to direct the overall sequence of events. The first person involved in the process—the clerk who writes the warrant—is usually an attorney, and he sees his responsibility simply as assuring that the request for assistance is placed in the correct form to present to the judge. The judge recognizes full well that he is not a psychiatric expert and that when he is in doubt he must call for a psychiatric examination. He is accustomed to directing that people be placed in police custody and, in the normal course of his day, the signing of a Section 78.4 warrant is likely to be a small matter. Furthermore, the signing of the warrant is just one step in the whole process. In carrying out his part of the procedure the magistrate need not see himself as responsible for the outcome of the entire case. Similarly, the police probably see themselves as simply carrying out the magistrate's order.

At the hospital the examining psychiatrist usually has little or no information concerning the patient's history. He has established no doctor-patient relationship and probably considers himself to be as accountable to the magistrate as to the patient and the patient's family. He does not see himself as making the key decision but rather as contributing one decision in a complex process, most of which has run its course before he becomes involved. Furthermore, he may justifiably feel that most of the decision making up to that point has been carried out by amateurs who have as much influence upon the outcome as he does, perhaps more. Although he is the expert, he does not have authority commensurate with his expertise.

Restriction to the Most Difficult Cases

In addition to the use of a warrant to assure emergency hospitalization, at the time of this study the New York State Mental Hygiene Law provided for emergency hospitalization on the basis of several other criteria. These include: examination by two physicians; examination by a health officer, a director of community mental health services, or a physician designated by either of these officials; examination by a staff physician of certain designated general hospitals; and custodial detention by the police for actions that would constitute disorderly conduct. Each of these procedures (all of which require less involvement with the legal system than does the warrant) serves to screen out from the warrant system obvious cases of mental illness, persons from middle-class families who are knowledgeable enough to obtain the services of a physician or a social agency, and very serious psychiatric emergencies.

The remaining cases are likely to be composed of the poor, the ignorant, the borderline mentally ill, and the chronic cases that have been given up or excluded by local agencies and physicians. Thus the ironic situation has developed that the section of the law providing the weakest mechanism for decision making and accountability and the fewest and least attractive options for disposition is used to deal with the cases requiring the greatest degree of skill and resources. In the face of this burden, it is no wonder that the system performs poorly.

REFERENCES

1. Dershowitz AM: Psychiatry in the legal process: a knife that cuts both ways. Judicature 51:370–377, 1968
2. Committee on Psychiatry and the Law, Group for the Advancement of Psychiatry: Laws Governing Hospitalization of the Mentally Ill, Report No 61. New York, GAP, 1966
3. Wexler DB, Scoville SE, et al: The administration of psychiatric justice: theory and practice in Arizona. Arizona Law Review 13 (Special Issue No 1), 1971
4. Brakel SJ, Rock RS (eds): The Mentally Disabled and the Law, rev ed. Chicago, University of Chicago Press, 1971
5. New York Mental Hygiene Law, Section 78.4 (1964)

A Computer Interview for Suicide-Risk Prediction

BY JOHN H. GREIST, M.D., DAVID H. GUSTAFSON, PH.D., FRED F. STAUSS, M.S., GLEN L. ROWSE, M.S., THOMAS P. LAUGHREN, M.D., AND JOHN A. CHILES, M.D.

To establish the feasibility of using computers to interview suicidal patients, the authors developed a computer program, a mathematical prediction model, and a "subjective" data base; computer interviews were then administered to 22 patients. The authors obtained a summary of the clinical state of each patient as well as a prediction of whether he would make a suicide attempt or not. They found that the patients preferred the computer interview to talking to a physician. In a separate retrospective study, the computer was more accurate than clinicians in predicting suicide attempts.

TWO MAJOR AIMS of suicide prevention are recognizing those who are at high risk of attempting suicide and being available to hear "cries for help." There are several areas of difficulty that make it hard to recognize and hear cries for help from suicidal patients. First there are the myths, such as "The person who talks about suicide never does it," and "Don't ask about suicide; you may suggest something he hasn't thought of." Second, there is a general absence of knowledge about the usual course of suicidal ideation—a course that is generally reversible—and the problems underlying it. Third, one often feels embarrassment on learning of another's distress and fears uncovering one's own suicidal impulses, which may or may not be well repressed. Fourth, there is a strong tradition of individualism and a desire not to meddle or interfere in another's life (or death). These difficulties reduce our sensitivity to the suicidal person, make it hard to communicate with him, and therefore stand between the suicidal person and help.

Drs. Greist and Laughren are with the Department of Psychiatry, University of Wisconsin Medical School, 1300 University Ave., Madison, Wis. 53706, where Dr. Greist is Assistant Professor and Dr. Laughren is a resident. Dr. Greist is also Psychiatrist, Division of Mental Hygiene, State of Wisconsin. Dr. Gustafson is Associate Professor and Mr. Stauss and Mr. Rowse are graduate students at the School of Industrial Engineering, University of Wisconsin. Dr. Chiles is Assistant Professor of Psychiatry, University of Washington, Seattle, Wash.

This work was supported in part by Public Health Service grant MH-21348 from the National Institute of Mental Health and by a grant from the Foundations' Fund for Research in Psychiatry, New Haven, Conn.

The authors wish to thank the residents and staff of the Department of Psychiatry, University of Wisconsin Medical School, who described their patients and made predictions for this work, and the staff of the Psychiatric Intervention Unit, who used the program with their patients.

The establishment of suicide prevention centers represents one approach to these difficulties. More than 200 such centers currently operate and serve, at least theoretically, as a front line of defense against suicide by providing trained staff—often volunteers—to answer telephone "hot lines." Despite these services, the suicide rate has not decreased (1), and it has been found that very few people who commit suicide have called the prevention centers (2, 3).

At least two problems have compromised the successful application of the concept of the suicide prevention center. First and most important, although suicide prevention centers are more widely available than before, professional help still fails to reach the majority of those who commit suicide. In ten suicide prevention centers that were surveyed (4), only a third of the calls were made by people who had been considering suicide. In addition, physicians, clergymen, teachers, and attorneys all come into contact with people who are suicidal (5) and fail to recognize the risk or to attempt to effectively intervene once the risk is recognized. Second, the staff of the suicide prevention center is faced with a welter of facts and feelings from the suicidal person and may have difficulty making consistent decisions about the degree of risk. The staff member may forget to ask for useful information, bias the patient's response by the manner in which he conducts the interview, or fail to accurately weigh the individual risk factors in his final assessment of the risk.

Computers have been programmed to interact with patients with a variety of medical problems. Computers can directly interview patients, collect and provide verbal information (6, 7), monitor physiological functions (8, 9), serve as consultants to clinicians (10–12), and, by processing information according to selected decision models, make diagnoses, prognoses, and recommendations for treatment (13–15).

As a direct interviewing device, the computer can reliably collect data in a manner that is acceptable to patients from a wide range of educational and socioeconomic backgrounds. A computer interview is more economical than an interview by a physician, proceeds at the patient's pace, and can be available at any time. The very constancy of its interviewing technique (setting, question wording and sequence, time between questions, etc.) produces data from successive patients that vary as a function of patient difference rather than of differences in the interviewing technique.

The use of computers to diagnose illness has been tried in several settings and has shown promise (10, 16, 17),

but it is not yet widespread. The chief reason for the lack of greater success to date is that the data bases used for decision making have been both expensive and of poor quality. Medical records, which have been the main sources of data bases, are notoriously poor sources of information on patients. Information is frequently absent, incomplete, illegible, or inaccurate.

The development of a prospective data collection system (as through the use of the computer interview) will solve part but not all of the problem. Two limitations are the time required to construct a prospective data base and the fact that, since the importance of a piece of information may vary depending on the population that is being studied, data bases are not universally applicable once they are developed.

Another source of information that has served the medical field well for many years, but that has been almost totally neglected by computer scientists and decision analysts in the development of computer-based information systems, is the clinician. Stored in his mind are the knowledge and judgment developed during years of training and experience; he has an exceptional capability to analyze and interpret information in relation to a hypothesis. The clinician's weakness lies in his limited ability to assemble the varying impacts these pieces of information have on the hypothesis (18).

In 1968, the Computer-Aided Medical Decision-Making Research Project at the University of Wisconsin began to develop and test methods of quantifying the experience and judgments of physicians (19–21). These methods were then used to construct a data base that was harnessed to the computer, which both collected information from patients and processed it.

PROGRAM DEVELOPMENT

Eight psychiatrists were each asked to list all of the factors they took into consideration when they were evaluating patients with suicidal thoughts. Next, a meeting of the psychiatrists was held to discuss the factors they had chosen, reduce duplication, develop common definitions, and describe different degrees and symptom levels of the factors. Thirty-five factors and a total of 246 levels of these factors were finally obtained. Questions were then prepared for presentation in the computer interview.

One of the principal benefits of using subjective probabilities is the speed with which one is able to develop the data base. Two research assistants, working half-time, took six weeks to develop the interview and the prediction model into an operating system for routine use in a clinic. This time period allowed the assistants to identify symptoms, develop measures, collect probability estimates, and program the computer to conduct interviews, process information, and generate summaries for clinical use.

The Patient Interview

Twenty-two patients who had expressed suicidal ideas during their initial interviews at the Psychiatric Intervention Clinic, a crisis-oriented unit at the University of Wisconsin Hospital, were interviewed by computer. The average age of the 11 women and 11 men was 25; the ages ranged from 19 to 45. Each patient had been asked to take the computer interview as part of his initial evaluation and, although none had had prior experience with computer interviews, all agreed to try.

The patients were interviewed at a cathode-ray terminal that was connected by telephone and acoustic coupler to the University of Wisconsin Computing Center. A brief computer-assisted instruction sequence demonstrated the interview format and the terminal's capabilities to the patient and ensured that he understood the procedures before beginning the suicide-risk questions.

The questions appeared on the cathode-ray screen and the patients responded by pressing keys on the typewriter keyboard. Both open-ended and multiple-choice questions were used. The patient had the use of the entire keyboard to respond to open-ended questions (e.g., to give his name and his definition of his major problem, or to make additional comments when the multiple choices offered were not adequate). Multiple-choice questions and scaled questions were answered by pressing the number key corresponding to the appropriate choice. Both question formats included the presentation of the patient's response on the screen for his review before he pressed the "go" key and proceeded to the next question (see appendix 1).

The manner in which the computer branched from question to question depended on how the patient responded to each question in succession and permitted a level of complexity rivaling that of a human interviewer. Patients could return to earlier questions by pressing a "back" key, and could change their answers by pressing the "change" key and entering the new response. The computer determined the direction of the interview in several ways. For most questions, the patient had to answer before the next question would appear, although he could choose to skip certain particularly sensitive questions by pressing the "skip it" key. By following carefully specified branching paths, the computer asked all the appropriate questions of each person and excluded extraneous questions that would interfere with the smooth flow of the interview. The computer also had a screening mechanism that quickly terminated the interview if the patient consistently denied the existence of suicidal and/or depressive thoughts or problems and that allowed all other patients to receive the full interview.

Immediately after the interview, the computer produced a summary of the information that had been collected and four risk-state predictions. This summary was printed in less than two and one-half minutes.[1]

After the interview was completed, the computer asked a series of questions designed to elicit the patient's reaction to the interview. These evaluation questions were optional, but 21 of the 22 subjects completed them. The

[1]Details of the process by which the computer generates the risk-state predictions are available from the authors. For a discussion of the general concept and format, see Gustafson and associates (15).

TABLE 1
*Reaction of Patients to the Computer Interview**

Reaction	Suicidal Patients	Nonsuicidal Patients
Liked the interview	3.86	3.35
Felt comfortable	4.14	3.98
Could get ideas across	3.43	3.37
Could express feelings	3.48	3.47
Was asked right questions	3.29	3.53
Understood the questions	4.19	4.42

* The patients were asked to indicate their agreement with the item on a scale from 1 to 5 in which 1 = "not at all" and 5 = "extremely."

same questions were asked of 43 other subjects who were psychiatric patients but not suicidal and who had completed a computer interview dealing with general symptoms. As shown in table 1, the two groups of patients were not significantly different in the degree to which they liked the interview, felt comfortable during it, got their ideas across, got their feelings across, felt they had been asked the right questions, and understood the questions. There was a difference (not statistically significant) in the overall responses of the two groups to the question "Would you rather give personal or private information and symptoms directly to this terminal or a doctor?" Fifty-two percent of the 21 suicidal patients preferred the terminal to a physician, compared with 27 percent of the 43 nonsuicidal patients. The average completion time for the suicide interview (82 minutes) was longer than for the general symptom interview (48 minutes).

Predicting Risk of Suicide

The computer-generated risk-prediction model was tested in a separate retrospective study that compared the performance of the computer with the performance of clinicians in assigning patients to each of four outcome states. The first step in this study was to obtain completed profiles containing the same information that had been elicited from the suicidal patients in the computer interview for patients who had been seen in therapy. For this purpose, 42 psychiatrists, clinical psychologists, and psychiatric residents were asked to complete profiles for patients they had seen in therapy, describing each at a specified time and stating whether he had: 1) made a serious or lethal attempt on his life (Weisman and Worden [22] risk-rescue rating of 40 to 83) within three months of that time, 2) made a nonserious attempt (Weisman and Worden rating of 17 to 39) within three months, 3) continued to have distressing suicidal thoughts three months later but had made no attempt, and 4) stopped having suicidal thoughts within three months.

A total of 84 profiles was obtained and five patient profiles were randomly selected from each of the four outcome groups. This set of profiles was rated by a panel of eight University of Wisconsin psychiatrists, three clinical psychologists, and ten psychiatric residents. These clinicians were asked to assign, for each patient, a probability of occurrence to each of the outcome states. The computer also processed these 20 profiles and assigned probabilities to the outcome states for each patient.

TABLE 2
Percentage of Cases in Which the Correct Outcome Was Assigned a Probability Greater Than .50

Outcome	Prediction Source	
	Computer	Clinicians
Serious attempt	40	35
Nonserious attempt	40	5
Suicidal thoughts	60	62
No suicidal thoughts	80	43

Table 2 shows the percentage of cases in which the correct outcome was assigned a probability greater than .50. Neither the computer nor the clinicians performed very well, although the computer did better except in correctly assigning probabilities to the third outcome state, continuing suicidal thoughts.

Several clinicians indicated that their principal concern was not whether the patient made "serious" or "nonserious" attempts or whether he had continuing suicidal thoughts but whether the patient would actually make an attempt on his life. As a result, we combined the outcome categories so that they distinguished only between "attempt" and "no attempt." As shown in table 3, the computer successfully predicted 70 percent of the suicide attempts, while the clinicians predicted 40 percent. The computer successfully predicted 90 percent of the cases in which there were no attempts, and the clinicians 94 percent. The computer was more accurate than the clinicians in predicing suicide attempts ($p < .01$) and slightly less accurate in identifying nonattempters.

A second point that is relevant to this evaluation is the certainty with which a prediction is made. A clinician might be more confident in his choice of a method of therapy if the probability of an attempt were 90 percent than if it were 51 percent. The magnitude of the probability assigned to the correct prediction was therefore calculated for each clinician and for the computer. The results, shown in table 4, indicate that on the average the computer assigned a higher probability to the correct prediction. For instance, the average probability assigned to

TABLE 3
Percentage of Cases in Which the Outcomes "Attempt" and "No Attempt" Were Correctly Assigned the Highest Probability

Outcome	Prediction Source	
	Computer	Clinicians
Attempt	70	40
No attempt	90	94

TABLE 4
Comparison of the Average Probability Assigned to the Correct Outcomes, Expressed in Percentages

Correct Outcome	Prediction Source	
	Computer	Clinicians
Attempt	68	36
No attempt	94	88

"attempt" by the computer was 32 percentage points higher than that assigned by the clinicians. Even for "no attempt," the computer on the average assigned a probability that was six percentage points higher than that assigned by the clinicians. As table 5 shows, when the computer erred, it indicated less confidence in its predicted (and incorrect) outcome than did the clinician. This lower level of false negative predictions is a desirable trait.

Completion Times

Those patients who took longer than one hour and a half to complete the computer interview appeared to have psychomotor retardation or marked ambivalence about the questions, but all who began the interview completed it. Some of the patients who took more time appeared to be less disturbed after the interview, which suggests that the task of communicating with the machine may have been an ego-orienting experience.

Program Costs

The cost of the interview and the risk prediction program averaged $4.25 per interview during periods in which the University of Wisconsin Computer Center was in heavy use (8 a.m. to 6 p.m. on weekdays) and half that amount at other times. A scheduled reduction in computer center charges will reduce the prime-time costs to $3 per interview and the non-prime-time costs to $1.50.

DISCUSSION

Computer diagnostic programs have been developed for several areas of medicine (23–25) and appear to have performed about as well as the clinicians with whom they have been compared.

The performance of most currently available diagnostic programs is usually limited by the problems associated with gathering data on individual patients and by inadequacies in the data bases that are used to make decisions. Different mathematical models generally process data in approximately the same way and with the same degree of acceptability. Further refinement of these models seems to offer little promise of improving diagnostic accuracy (23).

Programs that overcome problems in data collection techniques and that have standardized data bases on which to operate will achieve broad acceptance. For example, programs that interpret EEG records and acid-base abnormalities, which rely largely on measurement of electrical current and laboratory reports, perform well and are commercially viable (10, 26). The diagnostic problems associated with predicting suicide are more complicated. There are no pathognomonic symptoms, signs, biopsies, or laboratory tests for risk of suicide; many variables may be important in its prediction. Consequently, the data collection techniques and the development of the diagnostic data base are far more important to the success or failure of the system than the mathematical processing techniques that are used.

The computer interview appears to be an efficient, effective, and acceptable method for gathering standardized, complete, and usable data directly from suicidal patients. In our case, the development of a subjective diagnostic data base was fast and economical, and it permitted rapid implementation of the complete system. In future models, predictions and estimations made by the patient may contribute to the establishment of a subjective data base that is more accurate. As time goes on, the systematic collection of prospective data by computer interview should provide actuarial data bases of the greatest possible accuracy, although subjective estimates will still be used in the case of new concepts for which an adequate statistical base has not yet been established.

Acceptance of a program of this type is related to the ease with which it can be used, the rapidity with which results are obtained, and, ultimately, the accuracy of the predictions that are generated. Computer interviews require little staff time and the prompt availability of the summary and risk prediction is reinforcing to the staff. The program addresses a difficult clinical area and, in our retrospective study, showed a greater degree of accuracy in prediction than experienced clinicians.

A direct consequence of using the computer is that both data collection and decision making are systematic. Human beings experience flashes of highly personal intuition in the course of asking for information and making decisions; a wide variability in the effectiveness of care results from these individualized and less systematic ways of operating. A therapist may forget to ask an important question and may forget (or decide not) to include some information in the process of making his decision. The computer, on the other hand, never forgets, once it has been programmed to ask the question; it will

TABLE 5
*Average Probability Assigned to Correct Outcome When the Incorrect Outcome Was Predicted**

Correct Outcome	Prediction Source	
	Computer	Clinicians
Attempt	26	21
No attempt	42	24

* Even though the highest probability was assigned to the incorrect outcome, a relatively high level of probability here indicates less confidence in the incorrect prediction.

also take every response into account in later decision making. The questions the computer asks, the weight it gives to individual factors, and the process by which it makes decisions are not only explicit but subject to later modification and reevaluation. If new evidence is gathered or if opinion changes so that new factors (e.g., electroencephalographic or biochemical findings or bondage behaviors [26–28]) are considered to be potentially valuable in predicting suicide risk, these can be programmed into the computer and made available to each subsequent user.

The acceptance of this interviewing technique by suicidal patients has been good. Half of the patients we interviewed said that they would rather give information of a private or personal nature to the computer terminal than to a doctor. Although the meaning of this finding is uncertain and is the subject of continuing research, we suspect that many people feel more comfortable describing such socially deviant behaviors as suicide to a clearly nonjudgmental interviewer. It is possible that the more anonymous the listener is, the easier the patient finds it to talk about a grossly deviant behavior. Travelers, for instance, will often reveal the intimate facts of their lives to fellow travelers, whom they do not expect to see again. Patients recognize that information about their deviant behavior is important and want their therapists to know it, but they have difficulty sharing it. The extent to which material is "repressed" and becomes or remains "unconscious" may reflect the degree to which a patient is concerned about the biases of the interviewer and the verbal or nonverbal feedback he will get, whether there is a basis in reality for this concern or not.

The work we have described is a pilot study. While the results indicate that clinicians could use the system as it stands, several areas of research and development remain. Although the results of our retrospective study show that the computer program is better able to predict outcomes than are clinicians, the program is based on patient profiles that were prepared by clinicians. For many reasons, the clinicians' descriptions may have been inaccurate. Knowledge of the patient's outcome might have colored the therapist's description of the patient (clinicians often consider suicide and suicide attempts as signs of therapeutic failure), causing him to either exaggerate or minimize the degree to which certain symptoms were present.

The patients themselves may not have responded to the interview in a way that was consistent with their clinical state. A patient with a low risk of committing or attempting suicide may have responded as if he were at high risk to ensure that he would get help. On the other hand, a seriously suicidal patient may have responded as if he were at low risk in order to retain the complete freedom he would need to carry out his suicidal intent. We do not know the extent of this kind of problem or its effect on the model's accuracy. Our current experience suggests that this is not a serious problem. Techniques for dealing with it are available if it should appear to be significant. A prospective evaluation is being undertaken to provide answers to these and to the more complex questions involved in different patient populations, treatment methods, and periods of follow-up.

Although the computer interview is no panacea in the difficult clinical area of suicide-risk prediction, the approach has the obvious merits of low cost, short development time, widespread and instant availability, standardized collection and evaluation of data, and easy modification to incorporate new knowledge or to test new hypotheses. The interview collects standardized data about important questions in a fashion that patients prefer to respond to—open-ended, scaled, and multiple-choice responses rather than dichotomous "yes-no" responses. As time passes, we will be able to modify the decision model by incorporating the more accurate actuarial data as they become available to replace the subjective data base.

We realize that the introduction of nonhuman devices into this sensitive clinical area will be criticized, but we would like to point out that the use of machines is not necessarily inhumane. We suggest that it is more constructive to find ways in which these developments can be made to better serve the patient-consumer and the therapist and to improve the overall quality of the care we offer.

REFERENCES

1. Weiner I: The effectiveness of a suicide prevention program. Ment Hyg 53:357–363, 1969
2. Lester D: Evaluation of suicide prevention centers. International Behavioral Scientist 3:40–47, 1971
3. Lester D: The myth of suicide prevention. Compr Psychiatry 13:555–560, 1972
4. Whittemore K: Ten Centers. Atlanta, Lullwater Press, 1970
5. Murphy GE, Wetzel RD, Swallows CS, et al: Who calls the suicide prevention center: a study of 55 persons calling on their own behalf. Am J Psychiatry 126:314–324, 1969
6. Slack WV, Hicks GP, Reed CE, et al: A computer-based medical history system. New Engl J Med 247:194–198, 1966
7. Grossman JH, Barnett GO, McGuire MT, et al: Evaluation of computer-acquired patient histories. JAMA 215:1286–1291, 1971
8. Warner HR: Experiences with computer-based patient monitoring. Anesth Analg (Cleve) 47:453–461, 1968
9. Lewis FJ, Deller S, Quinn M, et al: Continuous patient monitoring with a small digital computer. Comput Biomed Res 5:411–428, 1972
10. Bleich HL: Computer evaluation of acid-base disorders. J Clin Invest 48:1689–1696, 1969
11. Bleich HL: The computer as a consultant. New Engl J Med 284:141–146, 1971
12. Menn SJ, Barnett GO, Schmechel D, et al: Computer program in respiratory failure. JAMA 223:308–312, 1973
13. Ledley RS, Lusted LB: The use of electronic computers to aid medical diagnosis. Proceedings of the Institute of Radio Engineers 47:1960–1965, 1959
14. Gustafson DH, Edwards W, Phillips LD, et al: Subjective probabilities in medical diagnosis. IEEE Transactions on Man-Machine Systems 10:61–65, 1969
15. Gustafson DH, Kestly JJ, Greist JH, et al: Initiated evaluation of a subjective Bayesian diagnostic system. Heath Serv Res 86:204–213, 1971
16. Jacquez A: Computer Diagnosis and Diagnostic Methods: Proceedings of the Second Conference on the Diagnostic Process, Held at the University of Michigan, Ann Arbor, Mich. Springfield, Ill, Charles C Thomas, 1972
17. Engle RC Jr: Computer-Aided Differential Diagnosis of Hemato-

logic Diseases: Digest of the Seventh International Conference on Medical and Biological Engineering, Aug 11–18, 1967, Stockholm, Sweden, p 194
18. Slovic P, Lichenstein S: Comparison of Bayesian and regression approaches to the study of information processing in judgment. Oregon Research Institute Monograph No 10. Oregon Research Institute, 1971
19. Van de Ven A, Delbecq A: Nominal and interacting groups for committee decision-making effectiveness. Journal of the Academy of Management 14:203–212, 1971
20. Gustafson DH, Kestly JJ, Ludke RL, et al: Probabilistic information processing: implementation and evaluation of a semi-pip diagnostic system. Comput Biomed Res (in press)
21. Gustafson DH, Shukla BK, Delbecq A, et al: A comparative study of differences in subjective likelihood estimates made by individuals, interacting groups, delphi groups, and nominal groups. Organizational Behavior and Human Performance 9:280–291, 1973
22. Weisman AD, Worden JW: Risk-rescue rating in suicide assessment. Arch Gen Psychiatry 26:553–560, 1972
23. Rinaldo JA, Scheinok P, Rupe CE: Symptom diagnosis: a mathematical analysis of epigastric pain. Ann Intern Med 59:145–154, 1963
24. Croft DJ: Is computerized diagnosis possible? Comput Biomed Res 5:351–367, 1972
25. Pipberger HV, Klingeman JO, Cosma J: Computer evaluation of statistical properties of clinical information in the differential diagnosis of chest pain. Methods Inf Med 7:79–91, 1968
26. Struve FA, Klein DF, Saraf KR: Electroencephalographic correlates of suicide ideation and attempts. Arch Gen Psychiatry 27:363–365, 1972
27. Bunney WE Jr, Fawcett JA, Davis JM, et al: Further evaluation of urinary 17-hydroxycorticosteroids in suicidal patients. Arch Gen Psychiatry 21:138–150, 1969
28. Litman RE, Swearingen C: Bondage and suicide. Arch Gen Psychiatry 27:80–85, 1972

APPENDIX 1

Three Examples of Computer Questions and Patient Responses

Q: Please describe your most serious problem or difficulty which is making you think of suicide. Take your time.
A: The thought of being depressed like this for the rest of my life is overpowering. Thinking that this is only temporary isn't any consolation. I'm sick of feeling good for six months, and then depressed for six months. I just don't see how I can continue.

Q: How many times a week does this problem occur on the average?
1) Not every week
2) Once or twice a week
3) Three to seven times a week
4) More than seven times a week
5) Present all the time
A: 3

Q: Type a number from 1 to 7 to rate how bad this problem has been for the last seven days.

Best						Worst
1	2	3	4	5	6	7

A: 3

Questions of the Month

Directions: Each of the incomplete statements below is followed by four or five suggested completions. Select the *one* that is BEST in each case.

Question 1: The latency phase of psychosexual development refers to

(A) the disappearance of sexual feelings and impulses
(B) a destruction of the young child's creativity and colorful behavior
(C) a more even balance of instinctual desires and ego strengths
(D) the impact of the newly established superego capacities
(E) none of the above

Question 2: The administration of chlorpromazine (Thorazine) will prolong a psychosis or panic reaction following the use of

(A) lysergic acid diethylamide (LSD)
(B) methamphetamine
(C) marijuana
(D) dimethoxymethyl amphetamine (DOM, STP)
(E) none of the above

(The Questions of the Month are from APA's Psychiatric Knowledge and Skills Self-Assessment Program: A Stimulus to Self-Learning. The answers are supplied on page 1337. References for the questions are supplied on page 1341.)

Psychiatry in the United States and the USSR: A Comparison

BY MARTIN G. ALLEN, M.D.

On the basis of personal observations made during a recent tour of the Soviet Union and on an investigation of the literature on Soviet psychiatry, the author presents a brief description of psychiatry in the USSR, a comparison of the Soviet and American systems of psychiatry, and a discussion of the advantages and disadvantages of each system.

THIS PAPER presents a review of the literature on psychiatry in the USSR, along with a report of my observations during the summer of 1971 while traveling in the USSR with a group of mental health professionals following the meetings of the International Psychoanalytic Association in Vienna. Because the tour was arranged through the American Psychoanalytic Association, the group was in general psychoanalytically oriented, and was regarded as such by our Russian hosts. However, the group was composed of psychiatrists, psychologists, social workers, and lay analysts who used a variety of therapeutic techniques.

Our group visited four cities in the Soviet Union: Moscow, Leningrad, Kiev, and Sochi (a resort area on the Black Sea). Like other visiting American professionals, we met with the psychiatrists at the Bechterev Institute in Leningrad and the Kashchenko Hospital in Moscow. In addition, we visited several sanitariums in Sochi. These sanitariums, which resemble resort hotels at a spa, offer the Russian citizen a combination of a vacation and a thorough medical evaluation, diet recommendations, sulfur baths, other physical treatments, and a good deal of rest and relaxation. Many sanitariums are operated by specific trade organizations; for example, all entertainers might go to one sanitarium and all miners to another. Each sanitarium has a complete medical team to evaluate the physical and emotional condition of the patient and provide treatment and relaxation.

In addition to observing Soviet psychiatric facilities and having the opportunity to meet with psychiatrists, I had been authorized by the NIMH to explore the possibilities of collaborating with the USSR in research.

PSYCHIATRY IN THE USSR

Detailed descriptions of Soviet psychiatry have been presented by Aronson and Field (1–8), Kline, Field, and Aronson (9), Kolb (10), Lebensohn (11–13), Ziferstein (14–20), and others (21–36).

As is the tradition in Europe, psychiatry in each major city of the Soviet Union is dominated by a different "school." In Moscow psychiatric treatment is predominantly organic, in Kiev the approach is behavioristic, and in Leningrad (traditionally considered the "gateway to Europe" and the most Western of Soviet cities) psychotherapy is emphasized. Although diverse treatment approaches are sometimes used within one geographical area, this is not typical. When we asked about the use of group therapy in Moscow we received the reply, "Oh, we don't do that here, but it is used in Leningrad."

I found the Soviet psychiatrists to be especially warm and friendly and very much interested in doing collaborative research. In discussing the etiology of mental illness they stressed heredity, biochemical factors, and adjustment to work; environmental factors were considered less important. Privately, however, several psychiatrists indicated that environmental factors were certainly important but that to "blame" environmental factors for illness might be interpreted as a criticism of Soviet society. Childhood is recognized as of "some significance" to behavior later in life but is not considered of major importance. Soviet psychiatrists acknowledge the existence of the unconscious, but do not make use of the concept in therapy.

In the USSR there is a government commitment to medical care. The basic premise is that excellent and readily available medical care (including psychiatric care) is a responsibility of the government and a right of every Soviet citizen (24, 30, 36). There is a centralized and standardized system for the planning and delivery of health services. Metropolitan and rural areas alike are divided into health care delivery sections, each section containing not more than 400,000 people. Large hospitals are available for hospitalization, and smaller "neuropsychiatric dispensaries" (somewhat like our community mental health centers) are available within each section. Mobile emergency psychiatric services are also readily available in many areas.

The Soviet Union has relatively large numbers of doctors and nurses and high staff-patient ratios. Eighty percent of the doctors are women (36). All personnel are well trained and well supervised. Each neuropsychiatric dispensary has 15 to 25 full-time psychiatrists, thorough records on patients, facilities for meeting specific needs (e.g., programs for children, workers, and alcoholics), and complete continuity of care. The dispensaries offer care to all citizens without regard to social or economic

Dr. Allen is Assistant Professor of Psychiatry and Director of the Group Therapy Training Program, Department of Psychiatry, Georgetown University School of Medicine, 3800 Reservoir Rd., N.W., Washington, D.C. 20007.

status. There is little citizen participation in the planning of mental health programs (although trade unions do participate extensively). Psychiatric services are provided within the medical system and in complete cooperation with it, and all mental patients are required to have treatment and follow-up visits if necessary (30).

Psychotherapy is short-term, directive, and supportive, with an emphasis on outpatient treatment, drugs, and day hospitalization. Almost all psychiatric treatment in the USSR is what we would describe as brief or crisis-oriented, rarely lasting for more than five or six meetings. After that patients are seen in the dispensary, where they receive medication and a brief session of supportive treatment. There is an emphasis on work as therapy, with the goal of improving the patient's relation to society and making him an active and productive member of society. The patient is paid for the work he performs and if necessary receives a pension afterwards.

In addition, the Soviet Union offers extensive programs of preventive psychiatry, including consultations to schools and factories; educational talks to laymen, school personnel, and professional groups; and examinations of persons in high-risk categories, such as persons who are acutely or chronically ill. Psychiatric consultations can be requested to deal with any social change. For example, there might be a consultation about noise levels when a new factory is constructed. Alcoholism is a significant problem in the Soviet Union and is increasing; drug abuse is almost nonexistent.

Psychoanalysis is not practiced in the Soviet Union and long-term psychotherapy is rare. Psychoanalysis is not considered "materialistic"—and therefore not scientific. It is thought to emphasize the erotic, ignoring the importance of the social environment and implying that man does not have control over his impulses (1). Transference is seen as a sign of a good relationship between the therapist and patient. In some cases a patient is helped to understand the basis of his "wanting to love the doctor." If the patient is unable to understand or cannot be made to see his distortion, he is assigned to another doctor. Little dream interpretation is done; it was described to us as "mystical." When the group reacted to that word, "mystical" was reinterpreted as "speculative." There is also no interpretation of defenses, conflicts, or unconscious processes. Lastly, Soviet psychiatrists do not themselves receive therapy as part of their training.

A COMPARISON

Appendix 1 presents a comparison of psychiatry in the United States and the USSR. There is always the possibility of generalizing too broadly about such large, complex, diverse societies as the United States or the USSR, compared with smaller, homogeneous, isolated societies (37). Nevertheless, as the appendix shows, some significant differences do exist between the two systems.

In general, the Soviet system of psychiatry presents a bias toward organic etiology, whereas the American system shows a bias toward environmental and experiential etiology. The Soviet Union emphasizes work and productivity in mental hospitals, high doctor-patient ratios, and the goal of improving a patient's relation to society in terms of the needs of society. In American mental hospitals and clinics, on the other hand, there is relatively more custodial care, passivity among patients, and low doctor-patient ratios. In America psychotherapy is practiced mostly with private outpatients, and the goals of therapy are oriented toward the individual—improving his situation in life and his sense of satisfaction. As Kolb has stated:

> The Soviet psychiatrists have relied and continue to rely upon the strengthening, development, or reconstruction of ego function and the alleviation of painful affect while giving less emphasis in treatment to analysis of conflicts, modification of defenses, and pathological adaptations through psychotherapy (10, p. 436).

A Soviet psychiatrist illustrated the difference between American and Soviet psychiatry by presenting the following example to our group. There was a disagreement between the Russian psychiatrists and Dr. Ziferstein, an American psychiatrist, over the case of a male Russian ballet dancer. The patient's chief complaints were vomiting and an "unsuccessful love affair." His history revealed that he had failed to pass his examination to become a starring dancer. The Russians' diagnosis was that his goals were too high for his abilities and that depression resulted from his failure to achieve. Dr. Ziferstein felt that sexual factors were most important. The patient was treated by the Russians for three months (described as an unusually long time); the treatment orientation was to help the patient accept more realistic goals.

ADVANTAGES AND DISADVANTAGES

It is apparent from this discussion and from the comparison presented in appendix 1 that the Soviet system of psychiatry has some definite advantages. These can be listed as follows (the basis for their selection is, of course, somewhat subjective):

1. Psychiatric care is readily available; there are many local district clinics and no waiting lists (2, 10, 13, 25, 30, 36).
2. The availability and type of treatment are not related to the patient's economic status (2, 7, 16, 25, 30, 36).
3. A strong, centralized, and standardized delivery system prevents duplication or overlapping of resources (2, 10, 17, 30).
4. The system offers extensive programs of preventive psychiatry, and every physician is required to engage in some preventive work (1, 2, 7, 10, 16, 21, 25, 30, 36).
5. Cases of illness are detected early and therapy is prompt (7, 16, 17, 23, 25).
6. Psychiatric services are provided within the medical system. There is complete coordination between psychiatric and all other medical services (7, 30, 36).

7. A well-organized, efficient ambulance service is available for psychiatric emergencies (2, 7, 30–32, 36).

8. There is an abundance of professional staff (doctors and nurses) and excellent staff-patient ratios—both in metropolitan areas and in outlying rural areas (every doctor is required to give three years of government service in any part of the USSR to which he is assigned) (7, 25, 30, 36).

9. The use of work therapy (as contrasted with occupational therapy) assures that the patient is provided with socially useful and productive work, for which he is paid. Such work also provides job training and preserves or develops work skills (2, 3, 7, 10, 16–18, 22–25, 30).

10. Day hospitalization and outpatient treatment are extensively used (2, 7, 10, 25).

11. There is good follow-up of patients, both for aftercare and to collect demographic information. Former patients receive well-organized continuity of care and home visits when necessary (7, 10, 22–25, 30, 36).

12. Recommendations (prescriptions) made for the patient, such as changing his job or place of residence, are binding on social institutions (2, 7, 10, 16–18, 22, 25).

13. If the nature of his illness permits outpatient therapy, the patient will not lose his job. If hospitalization is required, the patient is guaranteed a job upon discharge (10, 23).

14. Sanitariums are provided for rest and relaxation (2, 7, 26, 30, 36).

15. There is extensive training and supervision of all mental health personnel.

However, in comparison with the United States, Soviet psychiatry also has what can be considered some disadvantages:

1. Psychodynamics and environmental factors are minimized in considering the etiology of mental illness (30). From my discussions with Soviet psychiatrists, I believe this reflected a concern on their part that the implication of environmental factors in mental illness would represent a criticism of Soviet society itself.

2. Psychotherapy is limited to short-term, directive, and supportive approaches. Drugs are extensively used, and there is no orientation toward analysis of conflicts, a corrective emotional experience, or "working through" (2, 7, 10, 14–18, 25).

3. Civil liberties are limited by the system's commitment procedures. There is no opportunity for legal redress in the courts and no judicial review of civil commitment practices (23). The family, employer, or individual physician may initiate a commitment (2, 30).

4. The strong, centralized, standardized mental health system promotes some inflexibility and lacks diversity (2).

5. Clinical psychological testing is not done and is not regarded as useful (10, 30, 36).

6. Although there is extensive training of all mental health personnel, this training does not include therapy or any other program specifically aimed at self-understanding or personal growth.

CONCLUSIONS

In the United States there is a basic optimism that individuals can change themselves and their environment and a widespread belief that society exists for the fulfillment of individual needs. Psychotherapeutic models reflect this philosophy, emphasizing flexibility, insight, resolution of conflicts, and attainment of personal goals.

In the USSR, on the other hand, the prevailing philosophy is that individuals exist to further the goals of society. Psychiatric care, accordingly, is oriented toward primary prevention, delivery of services to the greatest number of persons, and helping the patient to adjust to society.

The United States has more sophisticated and diverse conceptualization and treatment models but poor programs of prevention and service delivery. The Soviet Union has developed superb organization and excellent prevention and delivery systems but rather simplistic treatment models. However, the Soviet and American systems of psychiatry are becoming more similar. The Soviets appear to have a growing interest in psychotherapeutic approaches and environmental factors, while in the United States there has been an increase in the use of organic therapies, community clinics, day hospitals, and shorter periods of hospitalization.

The question is whether it is possible for a society to have the advantages of both systems—that is, sophisticated, flexible therapies, readily available to all persons, offered by well-trained professionals, within a well-organized system responsive to the needs of the individual *and* society.

REFERENCES

1. Aronson J, Field MG: Mental health programming in the Soviet Union. Am J Orthopsychiatry 34:913–924, 1964
2. Field MG, Aronson J: The institutional framework of Soviet psychiatry. J Nerv Ment Dis 138:305–322, 1964
3. Field MG, Aronson J: Soviet community mental health services and work therapy: a report of two visits. Community Ment Health J 1:81–90, 1965
4. Field MG: Some problems of Soviet medical practice: a sociological approach. N Engl J Med 248:919–926, 1953
5. Field MG: Approaches to mental illness in Soviet society: some comparisons and conjectures. Social Problems 7:277–297, 1960
6. Field MG: Health services in the USSR. Soviet Survey 35:100–105, 1961
7. Field MG: Soviet and American approaches to mental illness: a comparative perspective. Review of Soviet Medical Sciences 1:1–36, 1964
8. Field MG: Soviet psychiatry and social structure, culture and ideology: a preliminary assessment. Am J Psychother 21:230–243, 1967
9. Kline NS, Field MG, Aronson J: Soviet psychiatric nomenclature. Am J Psychiatry 118:178–180, 1961
10. Kolb LC: Soviet psychiatric organization and the community mental health center concept. Am J Psychiatry 123:433–439, 1966
11. Lebensohn ZM: Impressions of Soviet psychiatry. Arch Neurol Psychiatry 80:735–751, 1958
12. Lebensohn ZM: The organization and character of Soviet psychiatry. Am J Psychother 16:295–301, 1962
13. Lebensohn ZM: discussion of LC Kolb, Soviet psychiatric organization and the community mental health center concept. Am J Psychiatry 123:439, 1966
14. Ziferstein I: Direct observations of psychotherapy in the USSR, in Selected Lectures from the Sixth International Congress of Psy-

chotherapy. Edited by Pines M, Spoerri T. New York, S. Karger, 1965, pp 150–160
15. Ziferstein I: The patient-therapist interaction in Soviet psychiatry, in Science and Psychoanalysis, vol 9. Edited by Masserman JH. New York, Grune & Stratton, 1966, pp 150–156
16. Ziferstein I: The Soviet psychiatrist: his relationship to his patients and to his society. Am J Psychiatry 123:440–446, 1966
17. Ziferstein I: The Soviet psychiatrist's concept of society as a therapeutic community. Current Psychiatric Therapies 6:367–373, 1966
18. Ziferstein I: Direct observations of pathogenic psychotherapy in the Soviet Union. Psychiatric Opinion 4(6):16–24, 1967
19. Ziferstein I: Soviet psychiatry—past, present, and future, in Social Thought in the Soviet Union. Edited by Simirenko A. Chicago, Quadrangle Books, 1969, pp 328–359
20. Ziferstein I: Group psychotherapy in the Soviet Union. Am J Psychiatry 129:595–600, 1972
21. Auster SL: Impressions of psychiatry in one Russian city. Am J Psychiatry 124:538–542, 1967
22. Babayan EA: The organization of psychiatric services in the USSR. Int J Psychiatry 1:31–35, 1965
23. Bazelon DL: Impressions of Soviet psychiatry: the law and the mentally ill. Am J Psychiatry 125:665–669, 1968
24. Gorman M: Soviet psychiatry and the Russian citizen. Int J Psychiatry 8:841–854, 1969
25. Hein G: Social psychiatric treatment of schizophrenia in the Soviet Union. Int J Psychiatry 6:346–361, 1968
26. Kline NS: The organization of psychiatric care and psychiatric research in the Union of Soviet Socialist Republics. Ann NY Acad Sci 84:147–224, 1960
27. Lesse S: Current clinical and research trends in Soviet psychiatry. Am J Psychiatry 114:1018–1022, 1958
28. Lesse S: Psychiatry in relation to communist philosophy. Am J Psychother 16:292–295, 1962
29. London ID: Therapy in Soviet psychiatric hospitals. Am Psychol 8:79–82, 1953
30. National Institute of Mental Health: First US Mission on Mental Health to the USSR. Public Health Service Publication No 1893. Washington, DC, US Government Printing Office, 1969
31. Snezhnevsky AV: Dispensary method of registering psychiatric morbidity and the Soviet system of psychiatric services. Living Conditions and Health 1:236–241, 1959
32. Torrey EF: Emergency psychiatric ambulance services in the USSR. Am J Psychiatry 128:153–157, 1971
33. US Department of Health, Education and Welfare: Report of the United States Public Health Mission to the Union of Soviet Socialist Republics. Public Health Service Publication No 649. Washington, DC, US Government Printing Office, 1959
34. Wortis J: Soviet Psychiatry. Baltimore, Williams & Wilkins, 1950
35. Wortis J: The thaw in Soviet psychiatry. Am J Psychiatry 119:586–588, 1962
36. Yolles SF: Impressions of the US mission on mental health: conclusions and recommendations. Am J Psychiatry 125:670–674, 1968
37. Allen MG: The study and evaluation of societies in cross-cultural research. International Mental Health Research Newsletter 5(1):1–4, 1963

APPENDIX 1

A Comparison of Psychiatry in the Soviet Union and the United States

SOVIET PSYCHIATRY	AMERICAN PSYCHIATRY
Psychiatric care is a state responsibility.	Psychiatric care is not considered a government responsibility. Care is provided by the state and private facilities to some segments of the population.
There is a centralized, standardized system for the delivery of psychiatric services.	There is no overall centralized or standardized delivery of mental health services. Delivery systems often overlap, compete, and provide poor or incomplete services in some areas.
Psychiatric services are provided within the medical system.	Psychiatry is often separate from medicine.
Most psychiatrists are women (about 80 percent).	Most psychiatrists are men (about 85 percent).
All mental health personnel receive extensive training and supervision.	Nurses and paramedical personnel receive little training or supervision.
Professionals do not have therapy as part of their training.	Many professionals have therapy as part of their training.
Psychiatric care is available in all localities and to all citizens.	The availability of psychiatric care is variable.
The availability and type of care are not related to economic status.	Availability and type of care are dependent on economic status.
All mental patients are required to have treatment and follow-up visits.	Only patients who are committed are required to have treatment.
Treatment goals relate to society—improving the patient's relations to society.	Treatment goals relate to the individual—improving the patient's situation in life and sense of satisfaction.
Citizens seldom participate in planning (although trade unions participate extensively).	There is some citizen participation in the planning of services.

SOVIET PSYCHIATRY	AMERICAN PSYCHIATRY
Emphasis is placed on physical causes of illness and physical treatment methods.	Emphasis is placed on psychological causes of illness and treatment methods.
Psychotherapy is short-term, directive, and supportive.	Psychotherapy is of variable length and may be supportive, directive, or analytic.
There is proportionately more outpatient psychiatric treatment and day hospitalization.	There is proportionately more inpatient psychiatric treatment.
Emphasis is placed on work as therapy.	Emphasis is placed on psychodynamics and insight.
There is complete continuity of care.	The continuity of care usually depends on patient motivation.
Emergency mobile psychiatric services are widely available.	No mobile emergency psychiatric services are available.
Preventive psychiatry is extensively practiced.	There are relatively few preventive programs in schools or factories or for high-risk groups.
Clinical psychological testing is not used.	Clinical psychological testing is sometimes used in evaluation and treatment.
Pensions are provided for the mentally ill.	Pensions specifically for mental illness are provided by some disability insurance programs and by the Veterans Administration—to some veterans.

Answers to Questions of the Month

Page 1332. Question 1: C; Question 2: D.

Shared Ethnic Scotoma

BY EDITH T. SHAPIRO, M.D., AND HENRY PINSKER, M.D.

A number of writers have advanced the opinion that it is beneficial to a patient to have a therapist of the same ethnic background. The authors point out that this may lead to "blind spots" that prevent the therapist from seeing the irrationality of certain of the patient's attitudes. They give three case examples that illustrate this point.

THE CONSCIENTIOUS PSYCHOTHERAPIST seeks to be aware at all times of the extent to which he is influenced in his work by his own political beliefs, social class, religion, and culture. He is careful to respect the differences between himself and his patients and to avoid applying to them values that are his but not theirs. In recent years, several writers have put forth the proposition that psychotherapy may not be effective unless the patient and the therapist share the same ethnic background (1–4). Experienced therapists who have successfully treated patients of diverse backgrounds are not likely to be unsettled by this assertion. Some of the young people who are now beginning to practice psychotherapy may regard this proposition as obvious, since one product of the social concerns of the past decade has been a new consciousness of ethnic differences. These social concerns, not clinical experience, have given rise to the idea that the patient and the therapist should be of the same ethnic background.

When patient and therapist share the same values and background, the erroneous beliefs or prejudices that they share may be ego syntonic to both and therefore not accessible to analytic scrutiny. The patient who seeks a therapist who "understands" his background is often looking for one who will agree that certain events or attitudes need not be explored or explained, but who will accept them as understandable, i.e., inevitable, consequences of the environment. The therapist who is ignorant of the facts about the patient's social and cultural background may attempt to understand cultural phenomena in terms of intrapsychic or intrafamilial processes. The therapist who shares his patient's origins may accept without question that which should be analyzed. Karno (5) stated that diagnostic errors and therapeutic failures in the diagnosis and treatment of Mexican-American patients resulted from the therapist's ignoring ethnic issues. He felt that these ethnic issues were avoided by therapists for fear they would appear prejudiced.

Apolito (6) proposed that Catholic therapists may have an advantage over non-Catholic therapists in treating Catholic patients. Familiarity with the religion makes it easier for the therapist to separate a pathologic defense with religious content from a genuine religious position. Ostow expressed the same idea in the context of Jewishness: "Because many psychiatrists fail to understand the experience of being Jewish, they are handicapped in their clinical assessment of certain symptoms . . . . Few non-Jewish psychiatrists comprehend the nature of the communal pulls, their pervasiveness and depth, and the strength of the historical forces to which young Jews are subject" (7, p. 553). Arlow, describing a case, concluded, "The success of the therapist's efforts was in large measure related to her knowledge of the child's cultural traditions and to her sensitivity to how these traditions affected [the patient's] psychological development" (7, p. 558).

These authors have emphasized the importance of knowledge, since a therapist who is of the same background as his patient is in a better position to know and understand him, but they do not suggest that non-Mexicans, non-Catholics, or non-Jews are incapable of such knowledge and understanding.

A different position has been taken recently by several authors who have written about the white therapist–black patient dyad. Sager, Brayboy, and Waxenberg (1) stated the issue succinctly: "Can a white middle-class therapist engage a black person in therapy?" They concluded that he could not.

Several writers have suggested that there may be crucial advantages to treatment of patients by therapists of the same race. Some say that a white therapist cannot, at this point in our nation's development, treat a black patient at all, since the long history of black-white antagonisms makes an open relationship impossible (1–3). Calnek pointed out that whites know little about the folkways and caste-motivated behavior of blacks and may misconstrue the latter as psychopathology (4).

Grier and Cobbs described some of the experiences their black patients face—broken families, the social emasculation of men, denial of opportunities, denial of access to the good things in life, and various types of hu-

Dr. Shapiro is Clinical Associate Professor of Psychiatry, College of Medicine and Dentistry of New Jersey at Newark, N.J.; her address is 201 Davison Pl., Englewood, N.J. 07631. Dr. Pinsker is Associate Clinical Professor of Psychiatry, Mount Sinai School of Medicine, City University of New York, and Chief, Inpatient Service, Beth Israel Medical Center, New York, N.Y.

The authors wish to thank Ms. Arlene Freedman, Librarian, Beth Israel Medical Center.

miliation—and stated that the life-style of blacks in America is unique (3). They concluded that the most important determinant of psychopathology among their patients was race.

Although these papers appear to express the prevailing view, dissenting opinions have been voiced. Simons and associates reviewed the literature in their article "Similarity, Credibility, and Attitude Change" (8) and found general agreement that similarities in background, including ethnic similarities, have an important bearing in situations in which one person is trying to influence another. However, they questioned the validity of some of the studies on which these conclusions were based; some studies showed that the most effective persuader is the one who is perceived not as identical but as superior.

Waite stated that the uniqueness of the individual precludes making generalizations, including generalizations about race (9). Carkhuff concluded that competence and skill are the most important factors in determining the effectiveness of teachers and therapists and that the influence of common ethnic or cultural factors decreases as the skill of the professional increases (10).

CASE REPORTS

The following clinical vignettes illustrate how shared backgrounds and values can present obstacles to treatment.

Case 1. An American-born woman, whose ambivalence about being Jewish led her to "pass" as a Christian throughout her school years but then to marry a practicing Jew, stated after some time in therapy that she now accepted the fact that she was Jewish. At the same time, she became free of the psychosomatic symptoms that had caused her to seek therapy. The therapist saw this as a signal of self-acceptance and, since he considered ethnicity to be an important part of the personality, would have regarded the therapy as effective if it had terminated at this point, as is the practice in brief, symptom-oriented treatment. Since the original agreement had been to pursue analytic treatment, however, he continued to see the patient. It became clear that the patient's apparent acceptance of her Jewishness was actually a manifestation of transference to the therapist, whose commitment to Judaism was known to the patient.

Case 2. A wealthy, attractive woman had been dismissed by several psychiatrists as a malingerer. She had repeatedly sued the German government for reparations for psychiatric symptoms resulting from her experience in a concentration camp. The woman revealed that she had not actually been in a concentration camp, but had spent the war in relative comfort by "passing" as a German. The psychiatrist initially felt anger at the patient's apparent attempt to exploit the suffering of others, and agreed that she was a malingerer. In time, he learned that the woman was indeed incapacitated by her symptoms and that grief, guilt, and shame over the experiences of the war years were significant causal factors in her illness. The psychiatrist then concluded that his initial anger and misdiagnosis stemmed from his assumption that because he was a Jew he knew what constituted normal behavior for survivors of the Nazi persecution.

Case 3. A Jewish woman entered therapy, after ascertaining that the psychiatrist was Jewish, with the goal of winning back her husband, who had left her. She said her marital difficulties had begun eight years earlier: she had stopped talking to her husband's sister, whose son had married a non-Jewish woman. The patient was angry at her sister-in-law for condoning the marriage and insisted that her anger was appropriate because of her past experiences and current style of life.

The patient had grown up in a German city that was too small to have its own Jewish community. She was totally rejected by other children and, because of her obviously Jewish appearance, was even harassed on the streets at times. After the Nazis came into power, she witnessed the ruin of her family and the transformation of the façade of polite business relationships into public humiliations, beatings, and blackmail. At 13, she was separated from her parents and deported with other Jews to a camp. There the group was told that every tenth Jew would be shot. She was among those to be shot; she pleaded with a woman to change places with her because she was only a child and had a right to live. The execution order was capriciously rescinded, and she was released. She joined a group of children that was allowed to enter Switzerland, where she was placed in a school. Eager to do well on an examination, she cheated and was caught. She was severely punished and told that as a Jew she was privileged to be in a school with "regular" children and was expected to behave with exceptional decorum and honesty to prove her worth. The therapist shared the patient's anger at a world that subjected Jews to such treatment. He felt he understood what she had experienced, and he believed that her reaction to her nephew's marrying a non-Jew was reasonable in view of her past and that her husband should have accepted her animosity toward his sister.

However, as the psychiatrist continued his attempt to understand the patient, he realized that she was actually a narcissistic and jealous woman who had recapitulated in adult life the disturbed intrafamily relationships of her early years. Like her mother, she was an only child; like her mother, she had one child only to placate her husband. Again like her mother, she coerced her husband into accepting her as a partner in his business, in which she then dominated and bullied him. She resented her husband's closeness to their daughter, his sister, and his nephew. Describing the ideal husband, the patient said, "He must adore me; he must give me everything I want. I want to be like a part of him, under his skin." In explaining her hatred for the nephew's wife, she said, "These stupid shiksas are used to drunken, bullying men, so a Jewish husband is a wonderful thing for them. She will spoil him, she will let him walk all over her. She will do anything for him."

The patient's low self-esteem had been reinforced by growing up in a society that branded Jews as outcasts. The social experience was not the primary agent of pathology, however. The nephew's choice of a non-Jewish wife was consciously experienced by her as repudiation of Jewish values; she perceived it neurotically as a symbolic rejection of herself as a woman and an act of independence by a man she wished to dominate. The experience of rejection forged a connecting link. Thus there was more to the patient's neurotic behavior than the therapist, who empathized with the patient's history of persecution, initially perceived.

DISCUSSION

The competent therapist is wary of his own initial impressions and should be able to revise them as he acquires

additional information. Much attention has been paid to the need for personal analysis to overcome blind spots in the therapist's own intrapsychic processes. But the scotoma associated with knowledge or values that the therapist has had for a long time is the least accessible to scrutiny. In recent years, certain beliefs about racial relations, the war in Viet Nam, the need to conserve the environment, etc., have become so widely accepted that younger therapists often find it difficult to distinguish between the objective importance of such issues and their importance as manifestations of early conflicts. Attitudes that are now considered to be sexist and chauvinistic were, until recently, thought by both therapists and their women patients to be quite natural and beyond question.

A well-known form of resistance in therapy is the involvement of the therapist in content areas that are socially important but therapeutically irrelevant. The greater the passion for the social concerns, the more difficult it is for the therapist to be aware that it is a form of resistance.

Many patients move from therapist to therapist, ostensibly in search of one who will understand their uniqueness. Implied in this search for understanding is the wish for unquestioning acceptance. The therapist who agrees that his patient's ethnicity is beyond the comprehension of others will facilitate the patient's use of this resistance maneuver. A prospective patient may be convinced from what he has read and heard that only a therapist who is ethnically similar can effectively treat him, or he may believe that his background cannot be explained adequately to an outsider. In such cases, the common background is used to seduce the patient into treatment; in time it should be understood as an unrealistic issue. The therapist who agrees that his patient's ethnicity is beyond the comprehension of others enhances the likelihood that the patient will employ his ethnic origins as a defense.

Many therapists are hampered by conscious and unconscious doubts about their professional knowledge. A therapist who agrees with his patient that their common ethnic background is an essential ingredient in therapy is minimizing the potency of psychotherapy per se.

Erikson said that ethnic identity "seems to be part of a psychosocial evolution by which [man] has developed into *pseudospecies* .... He becomes indoctrinated ... with the conviction that his species alone was planned by an all-wise deity, created in a special cosmic event and appointed by history to guard the only genuine version of humanity" (11, pp. 298–299). Erikson described identity consciousness as "aggravated self-consciousness" and went on to state that it is overcome only by a true sense of identity won in action (11).

Members of in-groups, be they policemen, disaster victims, minority groups, or the aristocracy, feel that there is some bond of understanding between them that is not shared by outsiders, and from this comes a feeling of security or superiority. Psychotherapists should not seek to use their relationships with their patients to serve their own needs for security and superiority.

In every therapeutic relationship, there is some level of agreement, some disagreement, and a large area that is free for evaluation about what constitutes psychopathology. Emphasis on the importance of shared ethnic origin tends to increase the area of agreement about what is and what is not individual psychopathology, but it also increases the risk that major defenses and significant areas of unconsciously motivated irrationality will escape detection.

Historical and clinical evidence does not support the proposition that common ethnicity is crucial for successful psychotherapy. Psychoanalysis has proven useful for Americans of widely differing backgrounds, yet in the 1930s and 1940s, psychoanalytic psychiatry in the United States was practiced largely by European refugees who were unfamiliar with the American culture and who had little common experience with their American patients. Until quite recently, almost all blacks who sought psychotherapy were treated by white psychotherapists.

The word "ethnic" is defined as "of or relating to races or large groups of people classed according to common traits and customs" and "ethnocentric" as "having race as a central interest; regarding one's own race or cultural group as superior to others" (12). Therefore the claim that a proper understanding of the patient is possible only when the therapist is of the same ethnic background may be a manifestation of ethnocentric bias.

CONCLUSIONS

The profound significance of ethnic consciousness as an integral part of the personality has been recognized, but along with this recognition has come an endorsement of ethnocentric bias. In this context, it has been suggested by some that optimal conditions for psychotherapy exist only when the patient and therapist have a common ethnic background. The competent therapist must always seek to understand the experience of his patient and to detect areas of impaired understanding that stem from differences between his life and his patient's. When values and assumptions are shared by patient and therapist, there is some risk that the irrationality of certain attitudes may escape the therapist's notice.

REFERENCES

1. Sager CJ, Brayboy TL, Waxenberg BR: Black patient-white therapist. Am J Orthopsychiatry 42:415–423, 1972
2. Poussaint A: A Negro psychiatrist explains the Negro psyche. New York Times Magazine, Aug 20, 1967, pp 52–53
3. Grier W, Cobbs P: Black Rage. New York, Basic Books, 1968
4. Calnek M: Racial factors in the countertransference: the black therapist and the black client. Am J Orthopsychiatry 40:39–46, 1970
5. Karno M: The enigma of ethnicity in a psychiatric clinic. Arch Gen Psychiatry 14:516–520, 1966
6. Apolito A: Psychoanalysis and religion. Am J Psychoanal 30:115–126, 1970
7. Ostow M, Blumenthal MJ, Arlow JA, et al: The Jewishness of Jewish young people: a symposium. Am J Psychiatry 129:553–561, 1972
8. Simons HW, Berkowitz N, Moyes J: Similarity, credibility, and attitude change. Psychol Bull 73:1–16, 1970

9. Waite R: The Negro patient and clinical therapy. J Consult Clin Psychol 32:427–433, 1968
10. Carkhuff RR: Black and white in helping. Professional Psychology 3:18–22, 1972
11. Erikson EH: Identity: Youth and Crisis. New York, WW Norton, 1968
12. Webster's Seventh New Collegiate Dictionary. Springfield, Mass, G & C Merriam Co, 1965

References for Questions of the Month

Pages 1332 and 1337.

Question 1: Senn MJE, Solnit AJ: Problems in Child Behavior and Development. Philadelphia, Lea & Febiger, 1968

Lidz T: The Person: His Development Throughout the Life Cycle. New York, Basic Books, 1968

Question 2: Creek FS: Illicit drugs found to be "mislabeled" as well as to vary widely in potency. Medical Tribune II, April 13, 1970, pp 1, 20

Psychiatric Residents: A Survey of Training Needs, Satisfactions, and Social Attitudes

BY FREDERICK E. FRIED, M.D., EDMUND G. DOHERTY, PH.D., AND LOLAFAYE COYNE, PH.D.

An intensive survey of the residents at one psychiatric training center revealed their views on a variety of personal and professional issues not previously studied in the literature. The authors investigated the residents' achievement levels, training needs, satisfaction with training, difficulty in formulating professional goals, attitudes toward their house staff organization (HSO), and opinions on various social issues. These data were correlated with their level of participation in the program's HSO, year of residency, and whether they were graduates of an American or a foreign medical school. The results of the study are reviewed in the context of the crises of role transition and the residents' professional development.

INCREASING CONCERN has been demonstrated in recent years about issues relating to the training and professional development of psychiatric residents (see, for example, the special section on "Residency Training" in the *American Journal of Psychiatry*, March 1972). Several studies have recently been conducted on the professional development of psychiatric residents as a function of their personality patterns, cultural backgrounds, previous training, and future goals (1–4). Other studies have examined the contributions of the psychiatric training center and its social system to the psychiatric orientation, personal growth, and professional development of the psychiatric resident (5, 6). With few exceptions, the existing literature provides sensitive analyses of these issues (7). Such studies have usually gathered data through the use of interviews with a small sample of residents, retrospective analyses or supervisor's impressions, or have been retrospective accounts of the author's own residency experience.

A search of the literature revealed few papers, however, that have systematically examined residents' perceived training needs, satisfaction with training, social attitudes, and other related issues of professional interest to the resident. In addition, participation in the training center's house staff organization (HSO) may play some part in the resident's personal and professional development. Yet there seem to be no data that relate personal characteristics of residents to their participation in an HSO. This paper will examine the relationship between degree of participation in one such HSO and certain attitudinal, performance, and demographic-biographical factors. In addition, we will attempt to provide information on residents' attitudes toward various current issues of concern to the medical profession in general and psychiatry in particular.

METHOD

The sample was composed of 57 of the 83 residents enrolled in the Menninger School of Psychiatry, a psychiatric training program known for its psychoanalytic orientation. Although all 83 residents enrolled at the time of this survey were members of the school's HSO, only 57 completed the survey instruments.

The subjects were white, had a mean age of 31.7 years, came from middle-class to upper-class backgrounds, and were considered to be representative in terms of their distribution according to year of residency (there are five possible years of residency in the training program). Three subjects were women. Twenty-five (44 percent) had received their medical training in countries other than the United States or Canada. The majority of the foreign medical graduates spoke Spanish, but all had a good command of English.

Procedure

The questionnaire that we designed examined a variety of characteristics. Residents were first grouped according to three variables: high versus low participation in the Menninger School of Psychiatry HSO, year of residency, and graduation from a foreign versus an American medical school. "High" participation in the HSO meant that the subject had held an executive office or had served as a committee chairman (N = 21). The remaining subjects, who had never held office, were classified as having low participation (N = 36). (In order to examine participation in the Menninger School of Psychiatry HSO in the context of the resident's total training experience, subjects were also asked whether they had ever stood for office in any other medical student or intern organization.)

These groups were examined in relation to the follow-

Dr. Fried is Assistant Professor, Department of Psychiatry, University of Missouri, Columbia, Mo. 65201; Dr. Doherty, formerly with the Menninger Foundation, is now Assistant Professor of Sociology, Wayne State University, Detroit, Mich.; and Dr. Coyne is Director, Statistical Laboratory, Research Department, Menninger Foundation, Topeka, Kans.

The authors wish to acknowledge the support of the Menninger Hospital Research Facilitation Committee, Dr. Philip Woollcott, and Dr. Peter Hartocollis.

TABLE 1
Sample Attitude Response Patterns (N = 57)

Item*	Strongly Agree 5	4	3	2	Strongly Disagree 1	Group Mean
More blacks should be sought out and treated in the training program, particularly through individual, group, and family therapy and in the inpatient service.	5	18	20	7	5	3.2
Steps must be taken to assure greater opportunities for a woman to be a psychiatrist, a wife, and a mother during residency training.	23	18	7	7	1	4.0
Emotional and social problems plague residents throughout their training and take the form of depression, emotional and physical exhaustion, anxieties over tremendous self-doubts, and ambivalence over the sacrifices that their profession imposes on them.	16	17	9	9	5	3.5
Residents should practice psychiatry, and not involve themselves in social issues such as antiwar demonstrations and welfare reform.	4	5	10	14	24	2.1

*For any particular item the total may not equal 57 because of individual nonresponse.

ing characteristics: achievement in somatic, social, and dynamic psychiatry; difficulty in formulating future professional goals; present training needs; satisfaction with training; congruence of attitudes; opinion on the proper role of the HSO; level of participation in any HSO during medical school, internship, or residency; and attitude response patterns relating to emotional and social problems among residents.[1]

Biographical data were also gathered since we felt that they might be related to the level of participation in the program's HSO. These data included mother's occupation, father's occupation, size of community of origin, military service, marital status, spouse's occupation, religion, and sibling position.

Instruments

To measure academic achievement, 18 sample multiple-choice questions from APA's Self-Assessment Program were incorporated in the questionnaire. Six questions were asked on each of the three areas of psychiatric orientation (somatic, social, and dynamic). The 18 questions also provided an overall achievement score for each resident.

To measure present training needs, each resident was asked to rate a list of 20 items describing typical areas of training (e.g., family therapy, formal didactic lectures, hypnosis, organic psychiatry) in terms of his need to acquire further training or experience in each area. The residents rated each item on a four-point scale ranging from "need much more of this kind of experience" to "feel no need for such experience."

A satisfaction-with-training scale was developed using the same 20 items. Subjects were instructed to indicate the extent to which they benefited from each training experience. Subjects rated each item on a five-point scale ranging from "an outstandingly profitable experience" to "an outstandingly unprofitable experience."

In order to determine the degree of difficulty subjects were having in formulating their professional goals, they were asked to respond to a 20-item list of areas of career concentration (e.g., private practice, education, research, hospital psychiatry) according to the percentage of time they planned to devote to each area. The subjects who responded with one main area of interest were considered to be having the least difficulty formulating ultimate professional goals; those not responding to any item or responding to more than five items were considered to be having the most difficulty.

In order to assess the residents' agreement or disagreement with current issues and concerns relating to the medical profession in general and psychiatry in particular, subjects were asked to fill out a 20-item Likert-type attitude scale composed of statements chosen from studies of and by residents in the recent literature (8–10) and from statements made by individual residents of the Menninger School of Psychiatry during the pilot phase of this study. Table 1 gives some examples of these attitudinal statements and presents the distributions and group means for the responses.

To determine whether first-year residents differed in their attitudes from more senior residents, a total congruence score was obtained from this attitude questionnaire by using the method of Kurtz and Kaplan (6) to calculate the sum of the differences between each subject's individual item scores and the mean item scores of the total resident group. A zero congruence score would represent complete agreement with or conformity to the group views.

Finally, the questionnaire focused on what the residents perceived as the proper areas of concern of a psychiatric HSO. Residents were asked to indicate how much they thought their HSO should concern itself with

[1] Detailed information on the methods of data analysis used for the various comparisons and the results of these analyses may be obtained from Dr. Coyne, Box 829, Menninger Foundation, Topeka, Kans. 66601.

a variety of issues relating to professional training and social reform.

RESULTS

Active participation in an HSO during medical school, internship, or residency and difficulty in formulating future professional goals were significantly related, with active HSO participants having more difficulty formulating future professional goals than inactive participants. A significantly greater proportion of active participants in the Menninger School of Psychiatry HSO were the children of career women. An analysis of residents for high versus low participation in the Menninger School of Psychiatry HSO showed no significant differences between the two groups in terms of academic performance, psychiatric orientation, or career patterns, nor was there a significant relationship between scores on the attitude scale and participation in the school's HSO.

The residents' achievement scores indicated that residents from all years performed significantly better in dynamic psychiatry than in somatic or socially oriented psychiatry. There was no significant difference noted in the academic performance of residents according to year of residency.

Our study showed that graduates of U.S. medical schools participated in HSOs to a greater extent than did foreign graduates and that U.S. graduates were more diversified in their professional interests than were foreign graduates. Although there was no significant difference in overall performance, U.S. graduates scored significantly higher than foreign graduates in the area of social psychiatry. U.S. graduates more often perceived the residency training years as being fraught with emotional problems than did the foreign graduates—in spite of the difficulties one might have expected the latter group to experience because of cultural adaptation.

As a group the residents expressed agreement with the following statements: residents should involve themselves in such social issues as antiwar demonstrations and welfare reform; everyone in the United States should be covered by tax-supported national health financing; steps should be taken to assure greater opportunities for a woman to be a psychiatrist, wife, and mother during residency; emotional and social problems plague residents throughout their training; psychiatric treatment is desirable for residents from both a personal and professional point of view; and institutions that provide health care should include in their policy-making bodies a sufficient number of consumers who reflect the demographic composition of the community using those institutions.

The residents participating in this study tended to maintain a more neutral stance in regard to the competence of foreign medical graduates and the need for recruitment of black residents. The majority felt that their training did not provide the experience they needed to function effectively as community psychiatrists. New residents did not differ significantly in their attitudes from more senior residents. There was no significant correlation between year of residency and attitude congruence.

The questions on curriculum and training needs revealed a desire by the residents for further training in the following areas (listed in rank order): community psychiatry, family therapy, group therapy, crisis treatment, organic psychiatry, encounter and marathon groups, and behavior conditioning training. They felt they received enough experience in formal didactic lectures, psychoanalytically oriented psychiatry, one-to-one treatment, and opportunities to teach. With the exception of the last item, each of these experiences was a major part of the Menninger School of Psychiatry training program.

The questions on satisfaction with training indicated that residents were most satisfied with their experience in theory of psychoanalytically oriented psychiatry, formal lectures, and theory and practice of group psychotherapies. Residents were least satisfied with their training experiences in research, practice of one-to-one psychoanalytically oriented treatment, organic psychiatry, and community psychiatry (in that order). One-third to one-half of the residents stated that they had had no experience with research, community psychiatry, or organic psychiatry. Seven new residents had had no experience in one-to-one treatment.

The data concerning the appropriate role of the HSO appear to indicate that the residents' mandate to their HSO was that it primarily represent their personal interests (salary, benefits, education) by serving as a liaison with the Menninger School of Psychiatry and only secondarily that it concern itself with social issues and community service.

DISCUSSION

Bucher, Stelling, and Dommermuth (1) contended that, in comparison to residents entering other major specialties, psychiatric residents have relatively limited prior experience with their field of specialty and that often the whole framework of the psychiatric residency curriculum is based on the assumption that the beginning resident lacks any substantial knowledge of psychiatry. The present study challenges these conclusions, since the performance scores disclosed no significant differences in academic achievement of residents according to their year of residency.[2] However, one might expect an increase in clinical skills and psychological insight over time.

Using fieldwork techniques and attitude scales, Strauss and colleagues (11) identified three major psychiatric ideologies in American psychiatry today: traditional psychotherapy, the newer sociotherapies, and somatotherapy. Our finding that residents from all classes performed significantly better in dynamic psychiatry than in somatic or socially oriented psychiatry might be antici-

[2] These data must, however, be reviewed with caution. Achievement was measured by a multiple-choice achievement test of 18 items—a small part of the total test items in APA's Self-Assessment Program.

pated in an institution that places great emphasis on psychoanalytically oriented therapy. In our study, U.S. medical school graduates performed significantly better than foreign graduates in social psychiatry, although in overall performance no significant difference was found. Perhaps foreign graduates felt less need to study social psychiatry, because of the anticipated difficulty of implementing it in their countries of origin, and thus preferred to concentrate in the areas of dynamic and somatic psychiatry.

The finding that residents who have actively participated in any HSO have significantly more difficulty than inactive participants in formulating future professional goals may be a reflection of the crisis in role transition that, according to Scanlan (12), many psychiatric residents undergo. Scanlan suggested that the student of psychiatry who has been trained in the medical model undergoes a precipitous change in social role and experiences considerable role shock as he reorients himself to his future role as a psychiatrist. He may at this stage of transition "search for competence in other areas, such as academics, politics, how to make money, and how to change the system" (12, p. 1108). One might speculate that the painful necessity to acquire a mature professional identity, at a time when future goals are unclear, could cause the resident to turn to the HSO in an unconscious search for resolution of this identity crisis. The psychiatric residency is generally considered a time of extraordinary emotional stress in the life of the prospective psychiatrist (10). Our study indicated that residency is particularly stressful for American medical school graduates.

In the process of developing a professional identity the resident's behavior, according to Scanlan, "is marked by rapid shifts in polar positions" (12, p. 1109). Scanlan also wrote that the challenge the psychiatric resident faces at this stage in his professional development is to avoid the hazard of seeking final answers and closing himself to other viewpoints. Our finding that there were no significant differences in attitudes or attitude congruence according to class year would seem to contradict this view. However, the instruments employed in this study focused more on social issues than on the theory and practice of psychiatry and were not specifically designed to examine Scanlan's views. Further empirical research is warranted in this area.

As the resident integrates and consolidates his newfound role as a psychiatrist, he will face new role transitions. According to Scanlan, "Initially, he will be stiff in his new role, and he will feel lost when he experiences a conflict between his personal and his 'psychiatrist' responses" (12, p. 1109). Allen (13) reported that some residents feel that being a psychiatrist excludes them from certain positive, constructive activities of living. This conflict is related to the traditional position of anonymity advocated for the psychiatrist and the difficulty of distinguishing personal opinion from professional judgment. By participating in the HSO, the resident might be attempting to find a way of getting involved—not only with professional issues but also with contemporary social issues of a nonpsychiatric nature. However, the findings of our study suggest that residents do not expect such an outlet in their HSO, but rather view their organization as a "union" whose primary concern should be to protect their vested interests.

In the final stages of role transition, as outlined by Scanlan, the resident anticipates the transition from student to psychiatrist. The challenge to the student at this point is not only to concentrate on prospective career goals but also to recapitulate in a realistic way what he has and has not accomplished during his residency (12). The apparent difficulty most residents have in formulating professional goals may be related to a preoccupation at this stage with past accomplishments rather than with future plans.

Additional long-term studies of the psychiatric residency experience in various training programs might well be undertaken, not only to examine changes in attitudes and training needs over time and the differences among programs of various orientations but also to explore the impact of such an intense experience on the personal growth of the resident and on his family. Indeed, it is remarkable that so little is known about the residents' families and the personal growth and changes they undergo as the resident is experiencing what Scanlan has called the "crisis" of psychiatric residency training (12). Future studies might also focus on the role the psychiatric training center's HSO plays in preparing the prospective clinician for his future relationships with professional organizations and his future role as "clinician-executive" (14, 15).

REFERENCES

1. Bucher R, Stelling J, Dommermuth P: Implications of prior socialization for residency programs in psychiatry. Arch Gen Psychiatry 20:395–402, 1969
2. Holt R, Luborsky L: Personality Patterns of Psychiatrists: A Study of Methods for Selection of Residents. New York, Basic Books, 1958
3. Wasserman E, Yufit R, Pollock G: Medical specialty choice and personality: outcome and postgraduate follow-up results. Arch Gen Psychiatry 21:529–535, 1969
4. Holt R: Personality growth in psychiatric residents. Arch Neurol Psychiatry 81:203–215, 1959
5. Bucher R: The psychiatric residency and professional socialization. J Health Human Behav 6:197–206, 1965
6. Kurtz R, Kaplan M: Resident attitude development and the ideological commitment of the staff of psychiatric training institutions. J Med Educ 43:925–930, 1968
7. O'Connor C: Peer group influences on the choice of a psychiatric viewpoint. Arch Gen Psychiatry 13:429–431, 1965
8. Jones B, Lightfoot O, Palmer D, et al: Problems of black psychiatric residents in white training institutions. Am J Psychiatry 127:798–803, 1970
9. Bowers J: Special problems of women medical students. J Med Educ 43:532–537, 1968
10. Halleck S, Woods S: Emotional problems of psychiatric residents. Psychiatry 25:339–346, 1962
11. Strauss A, Schatzman L, Bucher R, et al: Ideologies and institutions. Am J Psychiatry 127:798–803, 1970
12. Scanlan J: Physician to student: the crisis of psychiatric residency training. Am J Psychiatry 128:1107–1111, 1972
13. Allen A: A note on the making of a psychiatrist: the transition from resident to private practitioner. Psychiatry 34:410–418, 1971
14. Blair SM: The psychiatric resident learns administration. MilitMed 132:694–697, 1967
15. Levinson D, Klerman G: The clinician-executive. Psychiatry 30:3–15, 1967

1973 Anniversaries

BY GEORGE MORA, M.D.

The author recalls this year's anniversaries of events and individuals prominent in the history of medicine, psychiatry, and psychology and briefly examines their practical or theoretical contributions to the field.

1673

RICHARD MEAD was born in Stepney, near London. A graduate of Padua and Oxford and a fellow of the Royal Society of Physicians, he was associated with St. Thomas Hospital in London and was physician to George II. In 1751 his *Medical Precepts and Cautions*, which had been translated from Latin, was published in London. In it he devoted a great deal of attention to mental diseases and considered the possibility that melancholia and mania were two clinical manifestations of the same disease. On the basis of a well-studied case, he argued that symptoms of mental illness improved as the patient developed a physical disease, which led to attempts to introduce an irritating factor as part of the treatment of mental disorders. One of the last of these attempts was based on the belief that epilepsy and schizophrenia were incompatible; this was erroneously viewed as the reason that shock therapy produced a beneficial effect. Mead died in 1754.

1773

In this year, Luigi Rolando was born in Turin. After graduating from the medical school of the University of Turin in 1793, he followed the King of Savoy to Sardinia when the French occupied the Piedmont. There he began important studies on anatomy and physiology, which he continued when he returned to teach at the University of Turin in 1814. His most important work is *Saggio sopra la vera struttura del cervello* (*Essay on the True Structure of the Brain*, 1809), a work based on extensive research in which Rolando stimulated or ablated different parts of the brains of a variety of animals. He found that minor damage to the cerebellum caused the animals to stagger, whereas complete destruction caused "locomotor paralysis." Later on, while studying the "processi enteroidei," i.e., the gyri of the forebrain, he described the central vertical fissure that divides the frontal from the parietal lobe. Although this fissure had been previously sketched by Vicq D'Azry in his anatomical picture of the brain in 1786, Rolando was the first to recognize its importance, not only for voluntary movements, but for intellectual operations as well. Subsequently the Frenchman Leuret gave Rolando's name to this fissure, a designation that is still used today. Although Rolando's concepts were later corrected and revised, his experimental work has been recognized as a pioneering endeavor in the history of neurophysiology. He died in 1831.

In October 1773, Eastern State Hospital, the first state-supported hospital in British North America exclusively for the insane, was opened in Williamsburg, which was then a very prosperous center in the colony of Virginia. Although it was originally capable of housing only a few patients (47 from 1773 to 1779), the hospital became famous in American psychiatry because members of the Galt family served as its superintendents from the date of the hospital's founding until 1862. The first "keeper," John Galt, a layman, was succeeded by William and then Dickie Galt. Other members of the Galt family (John Minson, John Minson II, and John Galt Williamson) served there as physicians. Patients admitted to the hospital tended to be "treatable" (i.e., they were not chronic patients) and the therapeutic philosophy was based on "moral treatment" not unlike that at the Bicêtre in Paris and at the Retreat in York, England.

Throughout the years, the hospital underwent many difficulties as a result of political upheavals and internal conflicts but it maintained a very good reputation. In the 1820s and 1830s the hospital initiated a program of farming by the patients. Dr. John Minson Galt II, who served as superintendent from 1841 to 1862, was one of the founders of the American Psychiatric Association and the author of *The Treatment of Insanity*, a book of excerpts from European monographs. He emphasized moral treatment, which included building individual relationships, the moderate use of drugs, a balanced program of kindness and firmness, occupational therapy (including music therapy and bibliotherapy), and even placing patients on local farms, as had been done for centuries in Ghèel, Belgium. From the early 1840s to the latter part of the century, the hospital went through a period of decline brought on by the problems related to the emancipation of Negroes, the increasing isolation of psychiatry in the South and its rapid development in the North, and the general social and economic decline of the South. The name of the hospital was changed to Eastern Lunatic Asylum in 1861 and later, in 1894, to Eastern State Hospital, its current name.

Dr. Mora is Medical Director of the Astor Home for Children, Rhinebeck, NY., and Research Associate, Department of History of Science and Medicine, Yale University, New Haven, Conn. His address is 32 Slate Hill Dr., Poughkeepsie, N.Y. 12603.

John Gregory died at the age of 49. He was born in 1724, graduated from the medical school at Aberdeen, and became professor of philosophy and then of medicine at the University of Aberdeen. Later he became professor of the practice of physics at the University of Edinburgh and physician to the King of Scotland. In his *A Comparative View of the State and Faculties of Man with Those of the Animal World* (1765), he opposed the theoretical trend of the German schools of iatro-mechanics and vitalism and submitted that considerable knowledge of human behavior could be obtained from comparative psychological studies. Later, in his *Observations on the Duties and Offices of a Physician; and on the Method of Prosecuting Inquiries in Philosophy* (1770), he suggested that physicians should be very sympathetic to patients who are afflicted with mental disorders.

James Mill was born in England. An economist by profession and a pupil of Jeremiah Bentham, he published his *Analysis of the Phenomena of the Human Mind* in 1829. This book is considered to be the first complete system of psychology based solely on the doctrine of associationism. Mill was influenced primarily by Hume and Hartley; he viewed the mind as a passive recipient of sensations that are bound together into complex ideas by the process of association. These so-called "mental mechanisms" are the basis of his psychology, which represents a transition between English empiricism and 19th-century epistemology and psychology. He died in 1836.

The German philosopher Jakob Friedrich Fries was born in Saxony. He was influenced primarily by Kant and occupied himself extensively with psychological issues. Many of his writings on psychology appeared in the *Schmids Psychologisches Magazin*; his writings emphasized the value of self-observation for the understanding of reality. Although his system, which anticipated experimental psychology, can be viewed as a "psychological anthropology," some of his observations are relevant to modern conceptions of psychopathology. He died in 1843.

J.C. Roller, the first psychiatrist in the state of Baden, was born in Pforzheim. He was physician at the mental hospital of Pforzheim and died in 1814.

1873

In this year, George Elias Müller's *On the Theory of Sensorial Attention (Zur Theorie der sinnlichen Aufmerksamkeit)* was published in Leipzig. Müller, born in 1850, is generally considered to have been the most outstanding psychophysicist since Fechner. A graduate of the University of Göttingen, he was greatly influenced by Lotze, eventually succeeded Lotze in the chair previously held by Herbart, and held it for 40 years. His laboratory of experimental psychology was considered to be second in importance only to Wundt's in Leipzig. His rigorous research was highly systematic and focused on psychophysics, vision, and memory. In 1878, five years after the publication of his first book, he published the *Foundation of Psychophysics*. As he continued his studies of psychophysics, he refined his methodology and extended the scope of his investigation to address the mind-body problem.

His basic thesis of "psychophysical axioms," i.e., correlations between the processes of consciousness and the processes of the nervous system, anticipated the so-called "isomorphic hypothesis" of Köhler and other gestaltists. Müller, however, remained faithful to the principles of associationism and, in his important work *The Viewpoints and Data of Psychophysical Methodology* (1903), opposed the trend in psychology toward emphasizing the importance of global processes. His later works include *On the Analysis of Mnemonic Activity* (1911–1917), *Complex Theory and Gestalt Theory* (1923), *Compendium of Psychology* (1924), and *On the Perception of Color: Psychophysical Investigations* (1930).

Among his many pupils were David Katz, who was later professor in Germany, England, and Sweden and who did research on the perception of color and space; E. R. Jaensch, who is known mainly for his research on eidetic imagery; Lillien Martin, an American who later became professor of psychology at Stanford University; and E. Rubin, a Dane who was the author of the famous studies of figure and background perception. In the field of experimental psychology, Müller is considered to be the spiritual successor of Wundt, who died in 1920. Müller was very active for many years in the Deutsche Gesellschaft für Experimentelle Psychologie. He died in 1934.

Oskar Pfister was born in Zurich to a very religious family. He became interested in psychology in his youth and wrote his Ph.D. thesis on the psychological origin of religious philosophy. He was an ordained pastor. He became influenced by Freud's ideas at the beginning of this century and a strong friendship and frequent correspondence developed between Pfister and Freud that lasted until Freud's death. In his first book, *The Psychoanalytic Method* (translated into English in 1917), and in all his successive work he tried to combine psychoanalytic principles with Christian doctrine. Together with E. Bleuler he founded the Swiss Society for Psychoanalysis, which was open to both physicians and laymen. In the 1920s, during a stay in the United States, he proposed a psychoanalytic interpretation of the healing ceremonies performed by the Navaho Indians. When he retired after 37 years of being a pastor, he published his most important book, *Christianity and Fear* (translated into English in 1948). He died in 1956.

The French psychiatrist Benedict-Augustin Morel died. He was born in Vienna in 1809, the son of a French serviceman, and grew up in Luxembourg and later Paris, where he studied medicine. Inspired by Jean-Pierre Falret, he devoted himself to psychiatry after graduating from medical school. He toured many institutions for the

mentally ill and defective in various European countries and published several historical studies. Particularly notable was his monograph *Du mouvement et du progrès des études bibliographiques sur l'aliénation mentale en Angleterre, en Italie, et aux Etats-Unis* (1847). He was named physician at the asylum of Mareville in 1848, where he introduced the teaching of psychiatry three years later, and he was named chief physician to the asylum of Saint-Yon in 1856.

The following year he published his well-known 700-page book *Traité des dégénérescences physiques, intellectuelles, et morales de l'espèce humaine,* which was richly illustrated. He was obviously influenced by the Darwinian ideas that prevailed in his time; his main thesis was that degeneration represented a derivation from the normal human type that could be transmitted by heredity, deteriorating progressively toward the extinction of the line. A simple nervous constitution could therefore lead to psychosis in succeeding generations, then to mental deficiency, and eventually to the full incapacitation and extinction of the family. The use of alcohol and narcotics was thought to be a predisposing factor to this condition. In his *Traité des maladies mentales* (1860), Morel based his entire conception of psychopathology on the theory of degeneration. (This theory gained great popularity in Europe; it even acquired political implications, since certain nations were supposed to be more "degenerated" than others.) In addition to his works on degeneration, Morel published many studies on cretinism and, in his later years, on legal-psychiatric medicine and the practical aspects of institutional psychiatry.

Sandor Ferenczi was born in Miskolc, near Budapest, to parents of Polish background. After his graduation from the medical school of Vienna in 1894, he practiced neurology and psychiatry for some years. He first met Freud in 1908 and a strong friendship developed between them. The following year, Ferenczi accompanied Freud to Clark University in Worcester, Mass. He was soon recognized as an outstanding therapist and wrote a number of important papers on clinical subjects, e.g., two papers in 1911 on the connection between homosexuality and paranoia and on the distinction between active and passive homosexuality and his essay "Stages in the Development of the Sense of Reality." Ferenczi founded the Hungarian Psychoanalytic Society in 1913 and was made professor of psychoanalysis in Budapest in 1919 (this was the first professorship of its kind).

His book *Thalassa: A Theory of Genitality* (1924, translated into English in 1934) was both a biological and a psychological treatment of sexual development. By the time this book came out, he had developed a new therapeutic technique, the so-called "active therapy," in which the patient was encouraged to act and behave freely in order to overcome repressed conflicts. Also in 1924 a book by Ferenczi and Rank called *The Development of Psychoanalysis* (translated into English in 1925) appeared; it presented an overview of the entire field of psychoanalysis with emphasis on the application of active therapy. Shortly thereafter Ferenczi developed the notion of "sphincter morality," i.e., a relationship between anal sexuality and a strict superego. In treating his patients, he relied increasingly on the technique of allowing the patient to develop a dependent and regressive stance. In 1926, he taught a very successful course on psychoanalysis at the New School for Social Research in New York City in which he advanced the concepts of ego psychology. His support of lay analysis, however, resulted in considerable resentment from many American psychoanalysts. In later years, his new therapeutic techniques, which anticipated many contemporary trends, caused dissent between him and Freud. He died in 1933.

In this year, Carl Stumpf's *On the Psychological Origin of the Spatial Representations* (*Über den Psychologischen Ursprung der Raumvorstellungen*) was published. Stumpf was born in 1848 and studied philosophy under Lotze at Göttingen; he graduated in 1868. In 1873, he became professor at Würzburg, where he developed a friendship with Brentano that lasted until his death. From there, he went successively to Prague, to Halle, to Munich, and, in 1894, to Berlin. He remained there until he retired and was succeeded by Köhler in 1921. Although he founded an institute of experimental psychology in Munich and expanded the institute in Berlin, he was not especially interested in experimental work. He opposed the associationism and psychophysical parallelism of Wundt and Ebbinghaus and maintained a philosophical orientation that was probably influenced by Brentano's aristotelianism.

His most famous work is *Tonpyschologie* (*Psychology of Tone*), which was published between 1875 and 1890. Stumpf was aware of the difference between functions and contents and assigned to psychology the study of the former and to phenomenology the study of the latter. In Stumpf's theory, which has been called a "psychology of acts," the function, or psychic process, is central, while "appearance" is the object of such a process and is not itself psychic in nature. Stumpf's main work, *Appearances and Psychic Functions*, appeared in 1906. He trained many students who later contributed to the gestalt movement, among them Koffka, Köhler, Lewin, and Wertheimer. Stumpf died in 1936.

Dr. J.L. Thurman, from 1838 to 1849 the superintendent of the famous Retreat in York (founded by William Tuke in 1796) and from 1849 to his death the director of the innovative mental hospital at Devize, Wiltshire, died in this year. Among his writings are: *State of an Institution near York, called "The Retreat" for Persons with Disorders of the Mind* (1840), and *Statistics of the Retreat near York; Consisting of a Report and Tables Exhibiting the Experience of That Institution for the Insane from Its Establishment in 1796 to 1840* (1840).

A number of noteworthy events occurred in 1873 in the United States:

Dr. William H. Rockwell, for 36 years the director of the Brattleboro Asylum in Vermont, died at the age of 73.

Several mental institutions were opened—the Hudson County Lunatic Asylum (220 patients) in Jersey City, N.J., under the superintendency of Dr. S.W. King; the Northern Wisconsin Hospital for the Insane (638 patients) in Winnebago, Wis., under the superintendency of Dr. W. Kenster; the Iowa Hospital for the Insane (initial capacity: 50; by 1885, 700 patients) in Independence, Iowa, under the directorship of Dr. Albert Reynolds; the Anchorage State Hospital (75 patients) in Anchorage, Ky., under the direction of Dr. C.C. Forbes; the Passaic County Lunatic Asylum (50 patients) in Paterson, N.J., under the directorship of Dr. C.L. Petry; the Cincinnati Sanitarium (50 patients) in College Hill, Ohio, under the directorship of Dr. W.L. Peck; and the Southern Illinois Hospital for the Insane (150 patients) in Anna, Ill., under the superintendency of Dr. A.T. Barnes.

The New York Society of Neurology and Electrology was founded. Its first president was Dr. M. Clymer.

A pamphlet by the psychiatrist Isaac Ray (1807–1881) entitled "Ideal Character of the Officer of a Hospital for the Insane" was published in Philadelphia. Dr. Ray was superintendent of the Butler Hospital in Providence, R.I., and the author of the famous *Treatise on Medical Jurisprudence of Insanity* (1839).

There were also a number of important events in Europe, including the opening of: the mental hospital of the canton of Vaud (350 patients) at Bois-de-Cery, Switzerland, under the direction of Dr. Adrian Rist; the Lancaster County Asylum (1,100 patients) at Whittingham near Preston, England, with Dr. Joseph Holland as the director; an institution for severely sick and incurable epileptics in Würzburg, Germany; a women's asylum (600 patients) on the Venetian island of San Clemente; and the Asylum of St. Urban (200 patients) near Langenthal in the canton of Lucerne, Switzerland.

The Società Freniatrica Italiana was founded in Rome. A. Verga served as president and S. Biffi as secretary. Its official publication was the *Archivio Italiano per le Malattie Nervose.*

Edouard Claparède was born in Switzerland. He was a cousin of Théodore Flournoy (1854–1920), who had initiated the practice of scientific psychology in Geneva, did research on perception and hypnosis, and served as president of the Sixth International Congress of Psychology, which was held in Geneva in 1909. Claparède, who with Flournoy founded the *Archives de Psychologie* in 1901, served as secretary of the International Congress for many years. When Flournoy died in 1920, Claparède became professor of psychology and director of the laboratory at the University of Geneva. He was a functionalist and was interested in the study of intellectual activities, particularly those of children. He founded the J.J. Rousseau Institute, which soon became world famous for its research in child psychology and its development of new methods of teaching. His most important publication is *Experimental Pedagogy and the Psychology of the Child* (1905). In 1920, he founded the International Association of Applied Psychology and served as its president. Early in the 1920s, Jean Piaget began his famous studies of genetic psychology at Claparède's laboratory and eventually succeeded him in the chair of experimental psychology and as the director of the laboratory. Claparède died in 1940.

The British psychologist Charles S. Myers was also born in 1873. He was a student of H.R. Rivers at Cambridge. In 1901 Myers became one of the founders of the British Psychological Society, of which he was the first president. In 1904, with Rivers and J. Ward, he founded the *British Journal of Psychology*. In 1913, he became the director of the new psychological laboratory at the University of Cambridge and in 1915 was elected a fellow of the Royal Society. In 1922 Myers became the director of the new National Institute for Industrial Psychology in London, the purpose of which was "the application of psychology and physiology to industry and commerce." He chaired the Seventh International Congress of Psychology, held at Oxford in 1923. Myers published his *Textbook of Experimental Psychology* in 1909, the first true textbook of experimental psychology with a manual for laboratory exercises. The book went through several editions and was later revised by F. Bartlett. Myers died in 1946.

John Stuart Mill, the son of James Mill and the author of *Systems of Logic, Ratiocinative and Inductive* (1843), died this year. He was born in 1806 and, under the influence of his father, built a positivistic doctrine of psychology that was later to be called "mental chemistry." This doctrine held that sensorial processes associate with one another to form a new product. Mill drew a distinction between the natural and the moral sciences; the moral sciences included psychology, ethology, and sociology and were based essentially on psychological principles. Mill stated that psychic processes occur in fixed ways that can be investigated by experimental methods. The personality is therefore the result of the sum of single psychic processes. Mill's system of logic was also derived from the principles of psychology.

Theodore Simon was born in France. When he graduated from medical school, he began an enduring association with Alfred Binet (1857–1911). Binet had been doing research in the laboratory of physiological psychology at the Sorbonne when Simon began working with him. In 1904, they were appointed to a group of educators, physicians, and scientists who were commissioned to organize special classes in the public schools. Binet and Simon (who was then chief of the Insane Asylum of La Seine Inférieur) worked very hard on this project. The result of their effort was the 1905 Binet-Simon Scale for the measurement of intelligence. It was composed of 30 items arranged in order of increasing difficulty. The student's score was obtained by summing the number of items that he had successfully answered. A few years later, they published the 1908 Binet-Simon Scale, in which mental age was introduced as a scoring factor. Eventually this scale was introduced in the United States by Goddard,

Kuhlman, and Terman, three psychologists from Clark University. In 1916, Terman published the so-called Stanford-Binet Scale. He adopted the notion of the intelligence quotient (IQ) that had been first introduced in 1914 by a German psychologist named Stern. In 1920, Simon employed the Swiss psychologist Jean Piaget in Binet's laboratory. It was there that Piaget made his first studies on genetic psychology. Simon died in 1961.

Special Section on Women in Psychiatry Available

ALTHOUGH the *Journal* has given up the practice of routinely making copies of its special sections available, we are making an exception in the case of the special section in the October 1973 issue titled "Women in Psychiatry and Medicine" because of the widespread interest in this topic.

The cost will be as follows: 1–10 copies, $1.25 each; 11–25 copies, $1.10 each; 26–50 copies, $1.00 each; 51–100 copies, 90¢ each. Prices for larger quantities are available on request.

Address orders to Publications Services Division, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009. Please enclose payment with order; checks and money orders are acceptable but stamps are not.

True and False Experts: A Second Look

BY DAVID S. WERMAN, M.D.

In 1878 Dr. Eugene Grissom examined a number of forensic and reform issues concerning psychiatry and attacked a colleague who had been critical of the profession. The ensuing confrontation between the two seems particularly significant today. Both from within and without, psychiatry is being criticized for its exclusiveness, élitism, and traditionalism. As was the case almost 100 years ago, the issue often seems to be less a matter of the substantive nature of the criticism and rebuttals than one of hostility toward psychiatry itself.

LESS THAN 100 YEARS AGO, the Association of Medical Superintendents of American Institutions for the Insane held its 32nd annual meeting at Willard Hall in Washington, D.C. At this meeting Dr. Eugene A. Grissom, superintendent of the Insane Asylum for North Carolina at Raleigh, read a paper titled "True and False Experts" (1). The paper examined the position of the alienist who serves as a court witness, but by the end of his presentation, which was received with enthusiastic applause, Grissom had aroused some feelings that led to a motion of censure. Later, Dr. William A. Hammond brought a libel suit against the *American Journal of Insanity* for publishing Grissom's paper.

Manifestly, Grissom's paper dealt with the qualifications and appropriate stance that the expert should adopt in a court of law, the execution of the insane murderer (which he deplored), and the relationship of responsibility and reasoning ability on the part of the insane criminal. However, there were questions that the paper more heatedly raised: Who is most knowledgeable and best able, from experience, to speak about the insane? Who is responsible for institutional reforms within psychiatry itself, whether these be administrative, scientific, or theoretical? How should one deal with colleagues who are believed to be unethical or fundamentally hostile to the profession itself? In his attempt to deal with these issues Grissom departed from his otherwise careful presentation and gave vent to intemperate remarks about another member of the Association.

Eugene A. Grissom, who was born in North Carolina in 1831, was a descendent of Oliver Wolcott, a signer of the Declaration of Independence. He studied law, taught public school, and received his medical degree from the University of Pennsylvania in 1848. During the Civil War he served as a captain in the North Carolina troops and was severely wounded at the Battle of Richmond. Subsequently he was elected and later reelected to the House of Commons for the State of North Carolina (Confederate States of America). After serving as assistant surgeon general of North Carolina, he was named superintendent of the Raleigh Insane Asylum, a position that he held for 21 years. He seems to have enjoyed an active professional life, belonging to many societies and serving as vice-president of the Medico-Legal Society of New York. Like many of his colleagues, he was keenly interested in forensic problems (2, 3), which were the subject of his paper.

His opening paragraphs set the theme of his paper: "The full recognition of the harmony that should exist between the claims of medical science and the demands of criminal law, is a social problem of the first magnitude." Although great strides have been made by members of the Association in altering medical jurisprudence "to secure substantial justice for the insane, or to defeat the pretences of the wicked," there have been persistent efforts "to turn back the hands upon the clock of time, and to return to ancient legal by-ways, long since abandoned for the open roads of scientific investigation. . ." (1).

He discussed in detail the plea of irresponsibility in criminal offenses and its connection with the expert witness. The individuals who qualify as experts, according to Chief Justice Shaw, were those "who have long been conversant with insanity in its various forms, and who have had the care and superintendence of insane persons. . ."; opinions of such witnesses "are of great weight, and deserve the respectful consideration of a jury" (1, p. 3). The idea that insanity is a medical illness rather than a demonic possession was gradually reflected in the language of the law and consequently led to the need for medical experts. To further educate the public in this matter, the medical profession must not permit "noisy charlatans to fill the public ear with sensational falsehoods to please a mob athirst for something strange to feed upon. . ." (1, p. 8).

However, Grissom noted, the status of the expert in insanity in the courts and before the public was still being discussed. It was a "strange anomaly" that the medical witness is cross-examined by a layman in order to demonstrate the former's ignorance. Some judges even charge the jury, in effect, to ignore the medical testimony. One can understand the upright judge, who speaks out of ignorance, but what can be said of men "who hide the Mephistopheles behind the cloak of the philosopher [and diffuse] a subtle moral poison . . . through the foun-

Dr. Werman is Associate Professor, Department of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, N.C. 27514.

tains of the great daily press ... [and] would drug a Christian people into moral insensibility and practical atheism" (1, p. 10).

Grissom noted that Drs. Woodward, Bell, and Brigham, among others, fought to "modify the expression of judicial opinion in regard to the proof demanded to demonstrate the existence of insanity," but that some courts still permitted the testimony of nonexperts. Grissom would accept such testimony only if it reported observations of the phenomena of insanity.

As for the question of the criminal's ability to distinguish right from wrong, he cited opinions to support the view that such ability should not of itself preclude the possibility of insanity. He quoted Griesinger: "At what limits must it be said that a man is blind? Is it only when he can no longer perceive a ray of light?" (4). He also cited Professor Ludwig Meyer of Göttingen, who noted that the diagnosis of insanity was based on the presence of a series of symptoms that the physician's experience had taught him were characteristic of insanity. Meyer deplored the fact that the law accepted only the irresponsibility of the insane when their thinking was "entirely abnormal," thus causing them to suffer the penalty of the law if they were at all coherent (5).

The expert's opinion, Grissom asserted, was based on many minor facts that could be grasped and unified by the expert. But what if the experts are of different opinions? Then the weight of their testimonies and their experience must govern.

Grissom felt that the expert must deal with the interests of the insane as well as those of society. The plea of lunacy should be disposed of before the trial. Compensation for this service must be made only by the state. The expert should be in the position of amicus curiae, whose tasks are history taking and evaluation of the criminal's physical condition and the influences of his heredity. "We are to avoid the substitute of names for realities. To test every case by its symptoms ... [is] an axiom of the medical mind; for physicians, within certain limits, every case is a law unto itself" (1).

Grissom asked: If there is "strength and profound moral dignity" in the expert who must consider his reputation and a human life, what is to be said of one who "traffics in human misery, who sells his opinion for gold?" The fierce denunciation that Grissom then launched never mentioned its target by name; this was unnecessary because William Alexander Hammond was then one of the best known physicians in the United States (3, 6–9).

Hammond was born in Annapolis, Md., in 1828. In 1849 he entered the U.S. Army as a physician, where he remained until 1860 when he left to become professor of anatomy and physiology at the University of Maryland. At the outbreak of the Civil War he reentered the Army and was rapidly promoted over men with greater seniority. In 1862 General McClellan appointed him surgeon general of the Union Army with the rank of brigadier general, a post he held until 1864. His tenure was charged with antagonisms that he provoked not only from other Army doctors but from Secretary of War Edwin M. Stanton. Hammond's administration is described as "masterful and forceful"; he initiated reforms that modernized military medical care. He was instrumental in developing hospital facilities for the wounded, thus bringing about lower mortality rates. He created the Army Medical Museum and encouraged the liberal issuance of medical books and journals. Some of his recommendations, such as a permanent hospital corps, an Army medical school, and a permanent Army hospital in Washington, D.C., were adopted by his successors. But his "arrogant and inflexible" behavior, such as his outright prohibition of commonly used medications, led to increasing conflicts with colleagues. He was charged with irregularities in granting contracts for hospital supplies and was court-martialed, demoted, and dishonorably discharged. President Lincoln rejected a review of the case.

Hammond settled in New York as an alienist and lectured on insanity at the College of Physicians and Surgeons and at other medical schools.

He was an indefatigable writer, publishing a play, several novels, and books on military hygiene, forensic aspects of insanity, and diseases of the nervous system. His several editorships included the *Journal of Nervous and Mental Disease*. He frequently served as an expert alienist and testified at some of the most widely publicized trials of the period. Despite his controversial views he became influential and by 1878 brought about a congressional action that called on the President to investigate his court-martial; this led to a reversal of his conviction. He was given back his appointment as brigadier general and returned to live in Washington, D.C., where he opened a private sanatorium for the treatment of nervous disorders.

In his paper Grissom described Hammond as a "criminal," a "poisoner of the fountain of justice," a "base informer," an "atheist," "infamous," "reckless," one of the "modern Spartans ... [consigning] the insane to the fate of wild beasts, just as the deformed child was flung from Laconian cliffs," and "a fabled vampire ... [with] the clink of money under ... [his] girdle" (1).

Despite this melodramatic invective, the evidence for his assertion that Hammond was a "false expert" was embodied in the trial of one David Montgomery, an epileptic who in 1872 was tried for the murder of his wife. The expert for the defense was Dr. M.G. Echeverria of New York. This trial marked the first time in American medical jurisprudence that the position of amicus curiae was taken by an expert (Hammond), who gave testimony simultaneously for both the prisoner and the people.

There is little doubt that the jury's verdict of murder in the first degree was significantly affected by Hammond's testimony. Echeverria's article on the trial, "Criminal Responsibility of Epileptics, as Illustrated by the Case of David Montgomery" (10), which appeared in the *American Journal of Insanity* in 1873, contained 23 pages of Hammond's testimony. It is clear that he did give "strikingly different answers to prisoner's counsel and to the district attorney respectively." But more to the point, in that it was crucial in leading to Montgomery's conviction and execution, was Hammond's unequivocal statement

that "deliberation takes away the idea of an insane act." Hammond himself contradicted this notion in another trial, where he asserted in testifying for the defense that "the insane are very persistent in their revenge. I have known men occupied with the idea of killing their keeper for years, and finally doing it." An autopsy revealed that the brain of Montgomery, who was known to be epileptic, showed evidence of severe, diffuse pathology.

Grissom criticized Hammond's books as "uncritically accepted and admired" and filled with "numerous rare diseases which he unerringly diagnoses." Even more unacceptable to Grissom was Hammond's appearance as the "philosopher who is to inaugurate social improvements, the medico-legal jurist who will readjust criminal law. . . ." If Hammond had his way, Grissom said, "the alienists, who are superintendents of the insane . . . are to be reformed out of existence, and the institutions administered under the new lights of such modern philosophy" (1). Grissom quoted from Hammond's monograph *Insanity in Its Relations to Crime* (11), in which Hammond compared the insane man who has committed homicide to the "wild beast and the mad dog. . . . What society requires is protection, and it has no more business as such with abstract justice than it has with any other bit of philosophy." Hammond called for the punishment of insane murderers "even though they be morally irresponsible for their acts, by reason of delirium, morbid impulse, emotional insanity, or any other form of mental aberration."

Dr. David Richard Wallace (3, 12, 13), an alienist from Texas and superintendent of the State Lunatic Asylum at Austin, discussed Grissom's paper. He praised his research but criticized the "maledictory" aspects of the paper and deplored the assault on personal character, in particular Grissom's denunciation of Hammond's atheism. In a free country, he declared, Hammond may "worship God . . . [as he sees] proper, or not at all . . ." (13). Finally, he offered a resolution of censure, declaring that Grissom's attack was "out of place and . . . calculated to do no good, but on the other hand to stir up strife and confusion, and therefore contrary to the spirit of science, and of the benevolent and humane work in which they engaged" (13, p. 167).

Dr. Isaac Ray seconded the resolution although he admitted that he had not had the opportunity to hear the paper when it was read (14). He was unsure of the justness of the motion of censure but stated that "we have no right to sanction personal attacks. It was a personal attack, surely, to call a person virtually a charlatan, *however true it might be*" (italics added). After further discussion, Dr. Kirkbride offered the following resolution, which was seconded by Dr. Grissom and unanimously adopted: "*Resolved*, That this Association reaffirms its declarations made on previous occasions, that it holds itself in no way responsible for any paper read before it, or for any sentiments expressed in its meetings, unless from a direct vote of the Association" (14). Wallace's resolution was later voted upon and also passed.

As was customary, the paper was published in the *American Journal of Insanity*. It appeared in the July 1878 issue, along with summaries of the proceedings of the annual meeting and Dr. Wallace's motion of censure. Details of Grissom's paper appeared in the lay and medical press. The comments of Dr. Ray and Dr. Kirkbride's resolution were published in the January 1879 issue (14). It was for the publication of Grissom's paper that Hammond brought a libel suit against the journal and its editors.

In the January issue the editors pointed out that the publication of Grissom's paper, as one read at a meeting of the Association, was an established policy that had existed for more than 30 years. They took note of an open letter that Hammond published after the May meeting, in which he described his libel suit. In addition, the editors labeled as groundless Dr. Wallace's insinuation that others were the authors of Dr. Grissom's paper. "As far as the editors of this journal knew then, and know now, and believe, the paper was solely Dr. Grissom's, an entirely responsible member of the Association." For these reasons the editors chose not to make any editorial comments (14).

For all practical purposes the Grissom-Hammond affair was at an end and the libel suit was dropped. Hammond continued, however, to be in the center of other storms. Two years later he was one of a group that was severely criticized by a special committee of the New York Senate and later by the editors of the *American Journal of Insanity* (15). This group of four men had drawn up a petition calling for an investigation of abuses in the management of New York insane asylums. The petition was published in the *New York Herald* (16), the newspaper that Hammond used as a vehicle for publicity. When the names of the petitioners were made public, most of them indignantly demanded that their names be removed, generally claiming that their names had been fraudulently obtained. The New York Senate committee asserted that "not one of the petitioners, medical or lay, so far as the committee are aware, has been inside the state institutions for several years past, and only some half dozen have been in any of the wards of the asylums."

One of Hammond's most publicized pronouncements was related to the trial of Charles Julius Guiteau for the assassination of President James A. Garfield in 1881. Hammond found Guiteau insane, suffering from "reasoning mania," but recommended that he be put to death as a "deterrent against future presidential assassins" (17). In his comments he was not able to justify his diagnosis either by reference to any of the then-accepted criteria of insanity elaborated by Pinel, Esquirol, or Morel or even by his own writings. The *British Medical Journal*, in an article titled "Guiteaumania," caustically commented, "There is just one description . . . to which Guiteau's case bears a striking resemblance; and that is his [Hammond's] own description of reasoning mania . . . prepared for the occasion . . ." (18).

Hammond's *Treatise on Insanity in Its Medical Relations* (19), published in 1883, was the first comprehensive text on insanity to be published since Benjamin Rush's *Medical Inquiries and Observations Upon the Diseases of the Mind* (20). Hammond's book is a potpourri of the

works of French and German alienists of the 19th century. Thomas Vernon Moore described it as containing many "crude speculations" (21). Its mechanistic-organic approach is typified by such notions as, for example, that increased use of the brain causes increased decay in its tissue, that intelligence is directly proportional to brain weight, etc. Hammond's treatments emphasized the liberal use of bromides for a wide variety of ailments, as well as diet, rest (which he confused with moral treatment), and baths.

Although it appeared one year after Grissom's paper, the ideas expressed in Hammond's paper "The Non-Asylum Treatment of the Insane" (22) were probably already known to Grissom. In this paper Hammond made several useful comments on the inappropriate hospitalization of the insane; but beyond these reasonable suggestions lay his notion that the insane could gain "nothing . . . by being sent to a lunatic asylum." He decried the insinuation of the state in medical care and the "vast expense" of taxpayers' money to build "palaces for the insane." He exaggerated and then decried the use of restraint in state hospitals. Writings such as these kept Hammond's name in prominence until his death in 1900.

Toward the end of Grissom's life he is known to have suffered a nervous breakdown and to have developed symptoms of general paresis. He sought relief through cocaine, morphine, and other drugs, but these were apparently inadequate, for on August 16, 1902, he committed suicide by firing a pistol into his brain (2, 3).

COMMENT

The dramatic confrontation between Grissom and Hammond seems to strike a particularly responsive chord in the reader today because of its many similarities with certain current issues. Both from within and without, psychiatry is being criticized for its exclusiveness, and its professionalism is decried as élitism. Psychiatrists are described as stubbornly and self-servingly clinging to outworn, traditional ways of thinking of and treating their patients. They are alleged to practice social, racial, and economic discrimination in overt and covert ways. Various programs are put forward to diminish psychiatrists' control over the practice of psychiatry. As was the case 100 years ago, the issue often seems to be less a matter of the substantive nature of the criticisms and rebuttals than one of hostility toward the field of psychiatry as such.

It is probable that Grissom's fierce denunciation stemmed from his awareness of Hammond's antipsychiatric views and his outrage that this wealthy and influential individual had apparently caught the public's credulous attention.

It is paradoxical and poignant that at the very time that Hammond was attacking psychiatry, the entire field was preparing to undergo a virtual revolution. It is unfortunate that despite his great intelligence and innovative ability Hammond was so caught up in his own war that he was unable to escape the limitations of his time.

REFERENCES

1. Grissom EA: True and false experts. Am J Insanity 35:1–36, 1878
2. Eugene Grissom, MD (obituary notice). JAMA 39:387, 1902
3. Kelly HA: Cyclopedia of American Medical Biography. Philadelphia, WB Saunders, 1912
4. Griesinger W, cited by Grissom EA: True and false experts. Am J Insanity 35:1–36, 1878
5. Meyer L, cited by Grissom EA: True and false experts. Ibid
6. WA Hammond, MD (obituary notice). JAMA 34:122, 1900
7. Stone RT: Biographies of Eminent American Physicians and Surgeons. Indianapolis, Carlson and Hollenbeck, 1894
8. Pilcher JE: Brigadier General William Alexander Hammond, Surgeon General of the United States Army, 1862–1864. Journal of the Association of Military Surgeons 15:145–155, 1904
9. Deutsch A: Military psychiatry: the Civil War, 1861–1865, in One Hundred Years of American Psychiatry. Edited by Hall JK. New York, Columbia University Press, 1944, pp 367–384
10. Echeverria MG: Criminal responsibility of epileptics, as illustrated by the case of David Montgomery. Am J Insanity 29:341–425, 1873
11. Hammond WA: Insanity in Its Relations to Crime, quoted in Grissom EA: True and false experts. Am J Insanity 35:1–36, 1878
12. Atkinson WB: A Biographical Dictionary of Contemporary American Physicians and Surgeons. Philadelphia, Brinton, 1880, p 245
13. Proceedings of the Association. Am J Insanity 35:163–167, 1878
14. Summary. Am J Insanity 35:480–483, 1879
15. Lunacy investigation (editorial). Am J Insanity 39:494–503, 1883
16. New York Herald, quoted in Lunacy investigation. Ibid
17. Deutsch A: History of mental hygiene, in One Hundred Years of American Psychiatry. Edited by Hall JK. New York, Columbia University Press, 1944, pp 325–365
18. Guiteaumania. Am J Insanity 39:62–68, 1882 (reprinted from Br Med J, June 24, 1882)
19. Hammond WA: A Treatise on Insanity in Its Medical Relations. New York, D Appleton and Co, 1883
20. Rush B: Medical Inquiries and Observations Upon the Diseases of the Mind. Philadelphia, Kimber & Richardson, 1812
21. Moore TV: A century of psychology in its relationship to American psychiatry, in One Hundred Years of American Psychiatry. Edited by Hall JK. New York, Columbia University Press, 1944, pp 443–447
22. Hammond WA: The non-asylum treatment of the insane. Transactions of the Medical Society of the State of New York 280–297, 1879

Manic-Depressive Illness: Linkage with the Xg Blood Group

BY RONALD R. FIEVE, M.D., JULIEN MENDLEWICZ, M.D., AND JOSEPH L. FLEISS, PH.D.

Manic-depressive illness and the Xg blood group, a genetic marker located on the X chromosome, showed measurable linkage in successive generations of six families. These data suggest that a dominant X-linked factor is involved in the transmission of manic-depressive illness within the families studied.

ALTHOUGH STUDIES of morbid risk (1–3) and twin studies (4–6) have shown heredity to be a major factor in the etiology of manic-depressive illness, the precise mode of transmission is still the subject of controversy. Recently, investigators have used genetic markers to study the transmission of manic-depressive illness more specifically (7–9) and the results of these studies favor X linkage. This report presents the results of linkage studies in four new and two previously reported families (7), assorting for manic-depressive illness and the Xg blood group.

Drs. Fieve and Mendlewicz are with the New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032, where Dr. Fieve is Chief of Psychiatric Research, Department of Internal Medicine, and Director of the Lithium Clinic and Dr. Mendlewicz (on leave of absence from Brugmann Psychiatric Institute, University of Brussels, Belgium) is Visiting Psychiatrist, Department of Medical Genetics; Dr. Fleiss is Research Scientist, Department of Biometrics, New York State Department of Mental Hygiene, New York, N.Y. The authors are also all with Columbia University, where Dr. Fieve is Professor of Clinical Psychiatry, Dr. Mendlewicz is Research Associate in Psychiatry, and Dr. Fleiss is Associate Professor of Biostatistics.

This work was supported by Lithium Clinic grants C48103 and C58173 from the Division of Local Services, Department of Mental Hygiene, Albany, N.Y.

The authors wish to thank John D. Rainer, M.D., for his criticism, support, and encouragement, and Ms. Mima Cataldo, for her technical assistance.

METHOD

The sample was obtained between January 1971 and October 1972 by screening all 120 manic-depressive patients referred to the Lithium Treatment and Research Clinic of the New York State Psychiatric Institute. We found four index patients whose pedigrees were informative for linkage analysis between manic-depressive illness and the Xg blood group and in which phase of illness could be determined. A pedigree was informative when the mother was demonstrably heterozygous for both the illness and the blood group, and when she had two or more offspring old enough (age 20 years or more) that the illness could be reliably diagnosed.

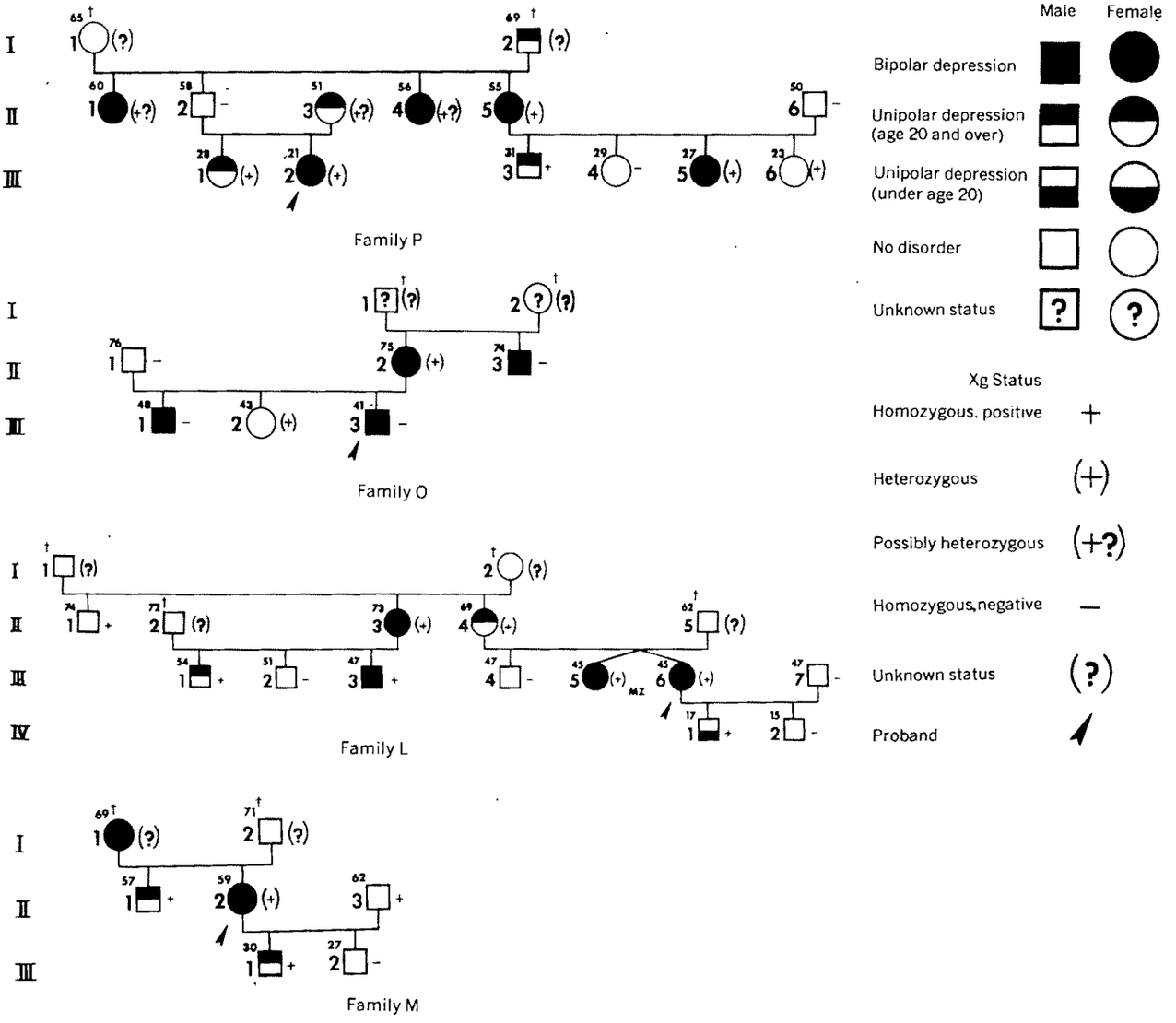
All probands as well as their spouses and available first-, second-, and third-degree relatives were examined blindly for the presence of the Xg blood group [1] and psychopathology. The diagnosis of manic-depressive illness in probands was made independently by two investigators using the criteria of Winokur and associates (10). Bipolar (manic-depressive) illness was diagnosed when there were clear-cut symptoms of manic and depressive behavior. Unipolar illness (depression only) was diagnosed when the subject had experienced one or more depressive episodes and had no history of mania or hypomania.

Symptoms required for diagnosis of mania included euphoria, hyperactivity, pressure of speech, decreased sleep, and irritability. Symptoms required for the diagnosis of depression included depressed mood and suicidal ideation or a decrease in appetite, sleep, energy level, or concentration. An episodic nature of the illness,

[1] The Xg blood group analyses were carried out by Dr. G. Allen of the New York Blood Center.

Topical Papers is a new section of the Journal. *The papers in this section are grouped around a given topic. Publication here does not, however, imply that the Editors consider this material to constitute a comprehensive analysis of the topic.*

FIGURE 1
Pedigrees for Four Families



symptom-free intervals, and lack of chronic deterioration were required for diagnosing both bipolar and unipolar disease. A semistructured clinical interview (11) was also used to confirm the diagnosis and evaluate current and past psychopathology in the probands and their relatives.

Although studies have indicated that unipolar and bipolar illness may be genetically different (12–15), all except one (13) found a higher than expected prevalence of unipolar illness in the relatives of bipolar probands. Furthermore, Zerbin-Rüdin's review (6) revealed that in a high proportion of monozygotic twins, both of whom had an affective illness, one twin suffered from bipolar and the other from unipolar illness.

Therefore, we assume in the present report that, *within a family pedigree identified by a bipolar proband*, bipolar and unipolar illness are genetically related and express the same genotype.

Statistical Methods

Each of a woman's ova has only one X chromosome. During the process of meiosis, some genetic material from one X chromosome may be exchanged for material from the other (i.e., crossing over may occur). The offspring who exhibit crossing over are called "recombinants," while those who exhibit no crossing over are called "nonrecombinants."

The relative frequency of recombinants versus nonrecombinants is a function of the distance between the two loci for the exchangeable genetic material. The more distant the two loci, the more likely it is, on the basis

of the laws of probability, that recombination will occur. Linkage between pairs of traits is in fact usually assessed by estimating the relative frequency of recombinants to nonrecombinants (technically, the "recombination fraction," denoted by θ). The minimum value of θ is .00, which indicates that the loci for the two traits coincide. The maximum value is .50, which indicates either that the loci for the two traits are on opposite ends of the same chromosome or that they are on two different chromosomes. The closer the value of θ is to .00, the stronger the evidence is for linkage. Edwards (16) presented tables that facilitate the estimation of θ. If the maximum likehood estimate for θ is significantly less than .50, the inference may be drawn that the loci for the two traits are linked.

LINKAGE RESULTS

Family P

The proband's paternal aunt, II (5), has bipolar illness and is Xg positive (see figure 1). She is heterozygous for the illness because two of her children, III (3) and III (5), are affectively ill and the other two are well, and she is heterozygous for the blood group because one of her children, III (4), is Xg negative and the others are Xg positive. This portion of the pedigree represents an instance in which daughters are informative for X linkage (usually, only sons are informative because they receive their single X chromosome from their mother). Since the aunt's husband, II (6), is well and Xg negative, an ill daughter can have received the gene for the illness only from her mother and an Xg-positive daughter can also have received the Xg-positive gene only from her mother.

The proband's father, II (2), is well and Xg negative. This suggests that the aunt, II (5), has the traits in *coupling*, i.e., that the alleles for the illness and Xg positiveness are on one X chromosome and that the alleles for no illness and Xg negativeness are on the other. Three of the aunt's offspring, III (3), (4), and (5), can therefore be counted as nonrecombinants because they are either ill and Xg positive or well and Xg negative. The fourth offspring, III (6), is counted as a recombinant because she is well but Xg positive.

Family O

The proband, III (3), has bipolar illness and is Xg negative. He has one brother, III (1), who is Xg negative and also has the illness, and one sister, III (2), who is well and is Xg positive. This represents another instance in which a daughter is informative for X linkage. The mother, II (2), is doubly heterozygous. Her brother, II (3), is Xg negative and has the illness, which suggests that the mother has the traits in *repulsion*, i.e., that the alleles for the illness and Xg negativeness are on one X chromosome and that the alleles for no illness and Xg positiveness are on the other. The three offspring, III (1), (2), and (3), are therefore counted as three nonrecombinants because they are either ill and Xg negative or well and Xg positive.

Family L

The proband, III (6), is a woman who is an identical twin and who is bipolar and heterozygous for the Xg blood group. Her two sons are too young to be counted for purposes of statistical analysis. Her maternal aunt, II (3), is bipolar and is heterozygous for the Xg blood group. She has three sons. III (1) is depressed and Xg positive, III (2) is well and Xg negative, and III (3) is bipolar and Xg positive. Their mother's brother, II (1), is well and Xg positive, which suggests that the traits may be in repulsion. We therefore count III (1), (2), and (3) as three recombinants.

Family M

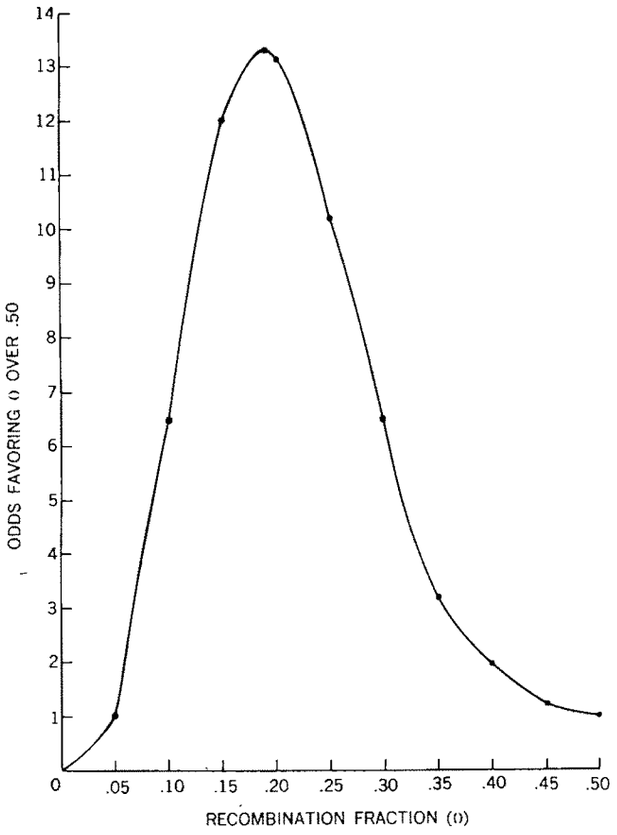
The proband has two sons, III (1) and III (2). One of them, III (1), has been hospitalized for depression and is Xg positive. The other son, III (2), is well and is Xg negative. The characteristics of the proband's brother, II (1), suggest that the traits are in coupling. Therefore, the pro-

TABLE 1
Logarithmic Odds for Linkage Between Manic-Depressive Illness and Xg Blood Group

Family	Method of Ascertainment*	Number of Offspring: Ill and Xg+ and Well and Xg−	Number of Offspring: Ill and Xg− and Well and Xg+	Recombination Fraction: .05	.10	.15	.20	.25	.30	.35	.40	.45
P	CMBC	3	1	−.18	.05	.14	.18	.17	.15	.10	.06	.02
O	CMBR	0	3	.81	.74	.66	.57	.47	.36	.24	.13	.04
L	CMBR	3	0	−1.47	−.92	−.62	−.42	−.28	−.18	−.10	−.05	−.01
M	CMBC	2	0	.52	.47	.42	.36	.29	.22	.14	.07	.02
W6**	CS2	3	0	.51	.45	.38	.31	.24	.17	.10	.05	.01
W7**	CS2	4	1	−.19	.02	.10	.12	.12	.09	.06	.03	.01
Total				0.00	.81	1.08	1.12	1.01	.81	.54	.29	.09
Antilog = odds favoring θ over .50				1.0	6.5	12.0	13.2	10.2	6.5	3.5	1.9	1.2

* See Edwards (16).
** See Winokur and Tanna (7).

FIGURE 2
Odds Favoring θ Over .50



band's sons are counted as two nonrecombinants.

The data were analyzed by the application of the logarithmic odds method of Morton (17) as tabulated by Edwards (16). The logarithmic odds for varying values of the recombination fraction (θ) between the Xg blood group and manic-depressive illness for the four pedigrees shown in figure 1 are presented in table 1, along with the log odds for the W6 and W7 pedigrees previously described by Winokur and Tanna (7). Also shown in table 1 are the antilogs of the sums of these log odds, which represent the odds favoring the given values of θ over .50, the value for the null hypothesis of no linkage. Analysis of these odds gives a maximum likelihood recombination fraction ($\hat{\theta}$) of .19. The odds favoring this value of θ over .50 are 13 to 1 (see figure 2). We can assert with better than 95 percent confidence that $\theta \leq .33$. Because this upper confidence limit is less than .50, the linkage is significant at $p < .05$.

CONCLUSIONS

The linkage data for the four new pedigrees in this report, along with the two informative pedigrees previously reported by Winokur and Tanna (7), provide evidence for measurable linkage between the Xg blood group and manic-depressive illness. These new findings strengthen the previous reports of X linkage in the families studied by Winokur and Tanna (7), by Reich and associates (8), and in our own laboratory (9), which demonstrated X linkage between protan or deutan color blindness and manic-depressive illness in seven families.

Perris (18) has reported that some manic-depressive fathers have affected sons, a finding that is inconsistent with X-linked inheritance. In our own population of 120 bipolar probands, nine families with apparent father-son transmission were also detected. What may account for these contradictory findings is genetic heterogeneity (19, 20).

In the present material, the odds reported are lower by a number of orders of magnitude than those which have been found in some of the best established linkages, such as those for glucose-6-phosphate-dehydrogenase deficiency and color blindness, in which the odds for close linkage with a recombination fraction of .05 are almost 3,000 to 1 (21). Nevertheless, measurable linkage was still demonstrated.

These findings indicate that at least in some families the pattern of inheritance is that of an X-linked dominant gene. In our previous report (9) we found close linkage between manic-depressive illness and deutan and protan color blindness. In this report, linkage between manic-depressive illness and the Xg blood group, although measurable, was found to be less close. Data published by Renwick and Schulze (22) indicated that the loci for the Xg blood group and color blindness are far apart. Our results are consistent with their report. The locus for manic-depressive illness appears to lie between the Xg locus and the color blindness loci, although it may be closer to the latter.

To the extent that these findings contribute to the determination of linkage between a gene involved in manic-depressive psychosis and a known marker gene on the X chromosome, manic-depressive psychosis represents the first instance, aside from certain mental deficiency syndromes, of the demonstration of a mendelian mechanism in psychiatric disorder.

REFERENCES

1. Slater E: The inheritance of manic-depressive insanity. Proc R Soc Med 29:981–990, 1936
2. Stenstedt A: A study in manic-depressive psychosis. Acta Psychiatr Neurol Scand Suppl 79, 1952
3. Kallman FJ: Genetic principles in manic-depressive psychoses, in Depression. Edited by Hoch P, Zubin J. New York, Grune & Stratton, 1954, pp 1–24
4. Rosanoff AJ, Handy LM, Plesset IR: The etiology of manic-depressive syndromes with special reference to their occurrence in twins. Am J Psychiatry 91:725–762, 1935
5. Slater E: An Investigation into Psychotic and Neurotic Twins. London, University of London, 1951
6. Zerbin-Rüdin E: Zur Genetik der depressiven Erkrankungen, in Das depressive Syndrom. Edited by Hippius H, Selbach H. Munich, Urban & Schwarzenberg, 1969, pp 35–36
7. Winokur G, Tanna VL: Possible role of X-linked dominant factor in manic-depressive disease. Dis Nerv Syst 30:89–93, 1969
8. Reich T, Clayton PJ, Winokur G: Family history studies, V: the ge-

netics of mania. Am J Psychiatry 125:1358–1369, 1969
9. Mendlewicz J, Fleiss JL, Fieve RR: Evidence for X linkage in the transmission of manic-depressive illness. JAMA 222:1624–1627, 1972
10. Winokur G, Clayton PJ, Reich T: Manic-Depressive Illness. St Louis, CV Mosby Co, 1969
11. Endicott J, Spitzer RL: The current and past psychopathology scale. Arch Gen Psychiatry 27:678–687, 1972
12. Leonhard K, Korff I, Shulz H: Die Temperamente in den Familien der monopolaren und bipolaren phasischen Psychosen. Psychiatr Neurol (Basel) 143:416–434, 1962
13. Perris C (ed): A study of bipolar (manic-depressive) and unipolar recurrent psychoses. Acta Psychiatr Scand 42 (Suppl 194), 1966
14. Winokur G, Clayton PJ: Family history studies, I: two types of affective disorders separated according to genetic and clinical factors. Recent Advances in Biological Psychiatry 9:35–50, 1967
15. Angst J, Perris C: Zur Nosologie endogener Depression: Vergleich der Ergebnisse der Untersuchungen. Arch Psychiatr Nervenkr 210:373–386, 1968
16. Edwards JH: The analysis of X linkage. Ann Hum Genet 34:229–250, 1971
17. Morton NE: Sequential tests for the detection of linkage. Am J Hum Genet 7:277–318, 1955
18. Perris C: Genetic transmission of depressive psychoses. Acta Psychiatr Scand 44 (Suppl 203):45–52, 1968
19. Mendlewicz J, Fieve RR, Rainer JD, et al: Manic-depressive illness: a comparative study of patients with and without a family history. Br J Psychiatry 120:523–530, 1972
20. Mendlewicz J, Fieve RR, Rainer JD, et al: Affective disorder on paternal and maternal sides: observations in bipolar (manic-depressive) patients with and without a family history. Br J Psychiatry 121:31–34, 1973
21. Porter IH, Schulze J, McKusick VA: Linkage between glucose-6-phosphate-dehydrogenase deficiency and color blindness. Nature 193:506, 1962
22. Renwick JH, Schulze J: An analysis of some data on the linkage between Xg and color blindness in man. Am J Hum Genet 16:410–418, 1964

The Dimethyltryptamine-Forming Enzyme in Blood Platelets: A Study in Monozygotic Twins Discordant for Schizophrenia

BY RICHARD JED WYATT, M.D., JUAN M. SAAVEDRA, M.D., ROBERT BELMAKER, M.D., STEPHEN COHEN, M.D., AND WILLIAM POLLIN, M.D.

Samples of the nondialyzed platelets of 14 pairs of monozygotic twins discordant for schizophrenia were assayed for their ability to enzymatically form the hallucinogen dimethyltryptamine. The schizophrenic twins had higher mean levels of enzyme activity than their nonschizophrenic co-twins, whose mean level of enzyme activity was equal to that of 22 normal subjects. This finding suggests that the higher levels of enzyme activity found in schizophrenics is produced by their environment and is not genetically determined.

WE RECENTLY DESCRIBED (1) an enzyme in the plasma, red blood cells, and platelets of normal subjects and alcoholic and psychotic patients that is capable of forming the hallucinogen dimethyltryptamine (DMT). The levels of enzyme activity in the plasma, red blood cells, and dialyzed platelets did not distinguish the patient groups from the normal subjects. The enzyme activity in the nondialyzed platelets of acute and chronic schizophrenics and psychotically depressed patients, however, was significantly greater than that of hospitalized alcoholic patients and normal volunteers. The finding that there were higher levels of enzyme activity in the nondialyzed platelets of psychotic patients and that this difference disappeared after dialysis suggested that the difference was due to a small, dialyzable enzyme inhibitor that is present in nonpsychotic persons but is either absent or diminished in those who are psychotic.

It has frequently been observed that biological markers of mental illness occur as a result of chronic illness, drug administration, and hospitalization (2, 3). The alcoholic patients included in our study were intended as a control for the effects of chronic hospitalization. To control for the administration of drugs, some acute schizophrenic patients who had never been given antipsychotic medication and some chronic schizophrenic patients who were receiving no drugs were studied; they were found to have higher than normal levels of enzyme activity. There were, however, no controls for the acute and chronic

At the time this paper was written, the authors were all with the National Institute of Mental Health, Bethesda, Md., where Dr. Wyatt is Acting Chief, Laboratory of Clinical Psychopharmacology, Dr. Saavedra is Visiting Scientist, Laboratory of Clinical Science, Dr. Belmaker is and Dr. Cohen was Clinical Associate, and Dr. Pollin is Chief, Section on Twin and Sibling Studies, Adult Psychiatry Branch; Dr. Cohen is now with the Department of Psychiatry, University of Vermont, Burlington, Vt. Address reprint requests to Dr. Wyatt at NIMH, Building 10, Room 4N206, Bethesda, Md. 20014.

TABLE 1
Clinical Characteristics, Impairment Ratings, and Platelet Enzyme Activity for 14 Pairs of Monozygotic Twins Discordant for Schizophrenia

Twin Pair Number	Age	Sex	Diagnosis*	Impairment Ratings**	Forced Rank Order***	Phenothiazines	Platelet Enzyme Activity (Counts per Minute) Index	Co-Twin
1	33	F	CUS	4	10	yes	137	60
2	30	M	CUS	4	13	yes	566	30
3	28	F	CUS	5	14	yes	204	109
5	37	M	CPS	4	9	yes	409	5
7	34	F	AUS in remission	2	2	yes	60	272
8	30	M	CPS	4	12	no	307	56
10	42	F	CPS	3	4	no	60	427
14	25	F	CUS in partial remission	3	7	yes	76	82
17	37	F	CPS	3	8	no	370	91
18	51	F	APS in remission	2	3	no	22	14
22	35	F	CPS in remission	3	6	yes	132	84
23	31	M	CUS	4	11	no	120	66
25	44	F	AUS in remission	3	5	yes	20	87
26	55	M	APS in remission	2	1	no	180	96
Mean±S.D.	37±9						190±164	106±112

*Diagnosis is shown for the index twin; in one case, pair 23, the co-twin had borderline social functioning. Abbreviations: CUS = chronic undifferentiated schizophrenia, CPS = chronic paranoid schizophrenia, AUS = acute undifferentiated schizophrenia, APS = acute paranoid schizophrenia.
**In two cases, pairs 23 and 25, the nonschizophrenic co-twin received an impairment rating of 1.
***The highest number indicates the one who is most ill.

stress that psychotic patients experience. Such controls have previously been shown to be extremely important in studying possible biochemical abnormalities in patients with mental illness.

One method of controlling for artifact-producing variables is to study monozygotic twins who are discordant for psychosis (4). If the psychotic and nonpsychotic co-twins have a given biochemical defect in common, it is unlikely that the defect merely reflects a process that is secondary to some aspect of being psychotic; the defect is probably genetically determined. In this regard, we have recently found that monoamine oxidase activity in blood platelets is low in some schizophrenic twins as well as in their monozygotic nonschizophrenic co-twins and have proposed that this be considered a possible genetic marker for vulnerability to schizophrenia (5, 6).

If a psychotic twin has the defect while his nonpsychotic twin does not have it, the defect is most likely the result of an interactive effect of environment on his biochemical makeup. The present experiment uses the discordant monozygotic twin method to determine whether the increase in the dimethyltryptamine-forming enzyme in schizophrenics is a primary biochemical defect or an effect present only in the phenotypically schizophrenic person.

METHOD

Fourteen pairs of monozygotic twins discordant for schizophrenia and 22 nontwin controls known never to have had a psychotic illness were studied. The twins had previously been examined for platelet oxidase activity, except for one pair who had been omitted from the monoamine oxidase study because of a laboratory error. Thirteen of the 14 twin pairs had participated in previous NIMH studies (7). The 14th pair were residents of the local area and members of the National Academy of Sciences/National Research Council twin cohort (8).

All the schizophrenic index twins had been hospitalized on one or more occasions for abnormal behavior diagnosed as schizophrenia; only one was currently hospitalized and five were now symptom free. Thirteen of the nonschizophrenic co-twins had never been hospitalized for a behavioral disorder, were not taking drugs, and generally functioned well within their families and communities. One nonschizophrenic co-twin had borderline psychosocial functioning. Only two of the twin pairs were living together in the same household at the time of the study; in ten cases the twins were living in different cities. Since eight of the schizophrenic twins were receiving phenothiazines, the natural course of their illness had probably been altered.

On the basis of a review of our previous records and an interview at the time of the blood sampling, diagnosis and degree of impairment were established for each twin; see table 1. The rating of impairment was based primarily on the number and length of hospitalizations, using a five-point scale: 1 = has a history of poor functioning at work and in interpersonal relationships and/or was hospitalized for a transient illness; 2 = was hospitalized with a clearly schizophrenic illness for more than one month but less than one year, but has functioned well since then (includes multiple hospitalizations within one year); 3 = has had two or more clearly schizophrenic episodes separated by at least one year, but is able to function at work or as a housewife while in remission; 4 = is unable to function at work or as a housewife even between hospitalizations;

and 5 = has been hospitalized continuously for the last five years.

The blood samples were obtained in the subjects' homes or in hospitals by methods previously described (1, 6). The samples were coded and assayed by an experimenter who had not been involved in obtaining them and who was unaware of their origins. The assay was carried out by incubating N-monomethyltryptamine with ^{14}C-S-adenosyl-*l*-methionine. The radioactive product was then extracted and counted in a liquid scintillation counter. Because we were unable to fully characterize the product of the nondialyzed platelets, the results of the assay are described in counts per minute per milligram of platelet protein (1).

RESULTS

The 22 normal subjects' mean level of enzyme activity (± standard deviation) was 123.5 ± 55 counts per minute; this was similar to the level found in the original group of 49 normal subjects (126 ± 7).

The mean enzyme activity for the schizophrenic twins was 190 ± 164 (in the earlier study it was 199 ± 15 for the chronic schizophrenics and 239 ± 42 for the acute schizophrenics). The level of enzyme activity for the schizophrenic twins was significantly higher ($p < .05$ by t test) than that for the normal controls, but not significantly different from the levels for their nonschizophrenic co-twins (106 ± 112), probably because of the wide standard deviation in both twin groups. A Pearson product-moment correlation between the schizophrenic and nonschizophrenic twins' platelet enzyme activity was not significant ($r = -.40$).

The five-point ratings of degree of impairment were subjected to a forced rank ordering using all available data about each patient. When this rank ordering of severity of impairment was compared with the levels of enzyme activity of the schizophrenic twins, it produced a Spearman rank order correlation (9) of .63 ($p < .05$).

DISCUSSION

In an earlier study we demonstrated that there was no difference between normal subjects and schizophrenic patients in the ability of their plasma, red blood cells, and dialyzed platelets to enzymatically form dimethyltryptamine. Nondialyzed platelet enzyme activity, however, not only distinguished between schizophrenics and normal subjects but also between psychotic depressives and normal subjects. The finding that the difference in enzyme activity was not specific to one diagnostic entity suggested that it was due to some common aspect of the illness, such as stress.

The present study confirms the findings of our earlier one in that the schizophrenic twins had higher levels of enzyme activity than a group of normal subjects. While the schizophrenic twins' mean enzyme activity was considerably higher (190 versus 106) than that of their nonschizophrenic co-twins, this was not demonstrated statistically, probably because of the wide degree of within-group variance and the limited number of twin pairs studied. The nonschizophrenic co-twins themselves did not, however, deviate from normal. These data, along with the negative correlations between members of a twin pair, suggest that the elevated enzyme activity is not a genetically determined trait.

We can offer two general explanations for the high levels of enzyme activity in the psychotic patients. One possibility is that the enzyme activity is elevated by some environmental factor occurring prior to the onset of the illness and is a biological marker for this occurrence. The second possibility is that the elevated enzyme activity is a secondary effect of the psychosis or something associated with it, such as stress. At present there are few data that can shed light on which of these two explanations is correct.

REFERENCES

1. Wyatt RJ, Saavedra JM, Axelrod J: A dimethyltryptamine-forming enzyme in human blood. Am J Psychiatry 130:754–760, 1973
2. Kety SS: Biochemical theories of schizophrenia. Science 129:1528–1532, 1590–1596, 1959
3. Wyatt RJ, Termini B, Davis JM: Biochemical and sleep studies of schizophrenia: a review of the literature—1960–1970, parts I and II. Schizophrenia Bulletin 4:10–66, 1972
4. Pollin W: A possible genetic factor related to psychosis. Am J Psychiatry 128:311–317, 1971
5. Murphy D, Wyatt RJ: Reduced monoamine oxidase activity in blood platelets from schizophrenic patients. Nature 238:225–226, 1972
6. Wyatt RJ, Murphy D, Belmaker R, et al: Reduced monoamine oxidase activity in platelets: a possible genetic marker for vulnerability to schizophrenia. Science 173:916–918, 1973
7. Pollin W: The pathogenesis of schizophrenia: possible relationships between genetic, biochemical, and experiential factors. Arch Gen Psychiatry 27:29–37, 1972
8. Hoffer A, Pollin W: Schizophrenia in the NAS-NRC panel of 15,909 veteran twin pairs. Arch Gen Psychiatry 23:469–477, 1970
9. Siegel S: Nonparametric Statistics for the Behavioral Sciences. New York, McGraw-Hill Book Co, 1956

Growth Hormone and Prolactin in Unipolar and Bipolar Depressed Patients: Responses to Hypoglycemia and L-Dopa

BY EDWARD J. SACHAR, M.D., ANDREW G. FRANTZ, M.D., NORMAN ALTMAN, M.D., AND JON SASSIN, M.D.

In response to both insulin-induced hypoglycemia and the ingestion of 500 mg. of L-dopa, unipolar depressed patients (most of whom were postmenopausal women) secreted significantly less growth hormone (GH) than did normal subjects or bipolar depressed patients in the same age range (45 to 70 years). Prolactin responses to L-dopa were normal for nearly all subjects. Since it is believed that prolactin responses to L-dopa are mediated by brain dopamine and GH responses by brain norepinephrine, the data tend to support the hypothesis that there is a disturbance of brain norepinephrine metabolism in unipolar depressive illness. However, further study is needed to determine the effects of the menopause on GH secretion.

WITHIN THE PAST FEW YEARS research has shown that the hypothalamic neuroendocrine cells whose hormones regulate anterior pituitary function are themselves subject to influence by brain monoamines (1). The evidence strongly suggests that secretion of prolactin from the anterior pituitary is inhibited by increased activity of dopaminergic neurons in the brain and is stimulated by decreased dopaminergic activity, apparently as a result of corresponding increases or decreases in the secretion of prolactin-inhibiting factor (PIF) by the hypothalamus (2–4). The secretion of growth hormone (GH) behaves inversely; it is stimulated by increases in catecholaminergic activity in the brain and inhibited by a reduction of catecholaminergic activity (4–6), probably as a result of corresponding increases or decreases in the hypothalamic secretion of growth-hormone-releasing factor.

Most of the evidence so far suggests that norepinephrine is the neurotransmitter that regulates GH release (5–8), although dopamine or dopaminergic receptors may also be involved (8, 9). The administration of L-dopa, a precursor of brain dopamine and norepinephrine, normally produces a fall in the level of plasma prolactin and a rise in the level of plasma GH in man (4, 10–14). Figure 1 illustrates the GH and prolactin responses of a normal 60-year-old woman to a 500 mg. dose of L-dopa. Intraventricular infusions of norepinephrine and dopamine provoke GH release in animals (6–8), while the depletion of brain catecholamines by the administration of alpha-methyl-paratyrosine and reserpine inhibits the normal GH response to insulin-induced hypoglycemia (15). The blockade of alpha adrenergic receptors similarly inhibits GH responses to hypoglycemia (16) and L-dopa (13) and reduces the basal GH secretion (17).

These patterns of neuroendocrine activity suggest the value of research on the secretion of GH and prolactin in patients with depressive illness, since it has been hypothesized that there is a disturbance of brain catecholamines—particularly a functional depletion of norepinephrine—in patients with depressive illness (18, 19).

A significant occurrence of inadequate GH responses to insulin-induced hypoglycemia has been reported among a heterogeneous group of depressed patients (20–22). A subsequent study reported significantly lower GH responses following the ingestion of 500 mg. of L-dopa in a group of psychotically depressed patients with unipolar histories (i.e., no history of manic episodes) compared with normal subjects in the same age range (45 to 69 years) (14). Both of these studies tended to support the hypothesis that there is a functional depletion of brain catecholamines in some types of depressive illness. There was, however, reason to believe that the GH responses of bipolar depressed patients (i.e., patients with histories of manic episodes) might differ from those of unipolar patients. Furthermore, it was not clear whether the deficient GH responses to L-dopa reflected a central neurochemical phenomenon or a failure of the L-dopa to enter the brain in sufficient quantities to induce a neuroendocrine response. Simultaneous measurement of plasma prolactin and GH could, it seemed, clarify the latter point: a positive prolactin response (i.e., a substantial

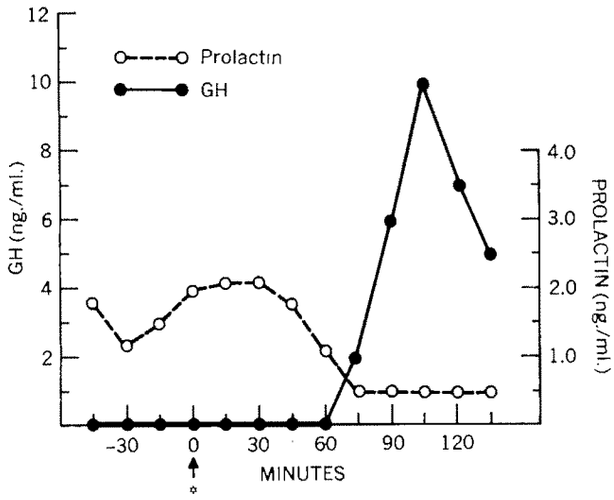
Presented in part at a New Research session of the 125th annual meeting of the American Psychiatric Association, Dallas, Tex., May 1–5, 1972.

Dr. Sachar is Director, Department of Psychiatry, Bronx Municipal Hospital Center, Eastchester Rd. and Pelham Pkwy., Bronx, N.Y. 10461, and Professor of Psychiatry, Albert Einstein College of Medicine, Bronx, N.Y.; Dr. Frantz is Associate Professor, Department of Medicine, College of Physicians and Surgeons, Columbia University, New York, N.Y.; Dr. Altman is Assistant Professor of Psychiatry and Dr. Sassin is Associate Professor of Neurology, Albert Einstein College of Medicine at Montefiore Hospital and Medical Center, Bronx, N.Y.

This work was supported by Public Health Service grants MH-22613 and MH-13402 to Dr. Sachar and MH-13041 to Dr. Altman from the National Institute of Mental Health; grants AM-11294 to Dr. Frantz and AM-14282 to Dr. Sassin from the National Institute of Arthritis and Metabolic Diseases; grant CA-11704 to Dr. Frantz from the National Cancer Institute; grant 68-111 to Dr. Frantz from the American Heart Association; and grant FR-53 from the General Clinical Research Center of the National Institutes of Health.

The authors are grateful to Alexander Glassman, M.D., and Samuel Gershon, M.D., who made several patients available for study; to Peter Grüen, M.D., and Grace Mushrush, M.D., who performed test procedures on several subjects; and to Henry Friesen, M.D., who supplied the human prolactin and antibody preparation used in these studies.

FIGURE 1
Growth Hormone and Prolactin Responses of a Normal Subject to 500 mg. of L-Dopa



*The L-dopa was administered at this time.

fall in plasma prolactin) would suggest that sufficient L-dopa had been converted to brain dopamine in these patients to induce the release of PIF.

The present study, then, was undertaken in order to extend the previous research on these neurochemical reactions. GH responses to insulin-induced hypoglycemia were compared among three groups of subjects: normal subjects (N = 9), unipolar depressed patients (N = 8), and bipolar depressed patients (N = 16). GH and prolactin responses to the oral administration of 500 mg. of L-dopa were similarly compared among three groups of subjects: normal subjects (N = 5), unipolar depressed patients (N = 19), and bipolar depressed patients (N = 8). Many of the same subjects who received the insulin test also received the L-dopa test.

METHOD

Subjects

All subjects, both normal and depressed, were physically healthy and between the ages of 45 and 70. None were receiving medication at the time of the study and none had received courses of treatment with drugs known to affect GH or prolactin secretion (5, 23) (e.g., phenothiazines, reserpine, hormones) within two months of the test. All subjects weighed within 25 percent of ideal body weight, and the three groups did not show significant differences in this respect. None of the normal subjects had a history of significant psychiatric disturbance. None of the depressed patients revealed any schizophrenic manifestations or had any history of schizophrenic episodes. All depressed patients were tested during a depressive episode. A modification of the Hamilton Depression Scale (24) was used to assess the patients and ensure that only those with "endogenous" depressive syndromes (25) were included in the study. All patients suffered in varying degrees from depressed mood, pessimism, anhedonia, ruminative worries, sleep disturbance, and difficulty in concentration and from diminished energy, interests, self-esteem, emotional responsivity, and sexual and aggressive drive. Most also manifested anxiety, anorexia, and agitation or retardation. Few, however, were frankly delusional. Depressed patients were considered to be bipolar if they had a history of at least one well-documented episode of mania.

Mean scores for severity of illness were not significantly different between the groups of unipolar and bipolar depressed patients. Most of the depressed patients had had previous depressive episodes. For those subjects receiving L-dopa, the mean age in the normal group was 58, in the unipolar depressed group it was 61, and in the bipolar depressed group it was 57. The 20 normal subjects included five women, the 19 unipolar depressed patients included 12 women, and the eight bipolar depressed patients included two women.

Procedure

All subjects were tested in the morning, following an overnight fast. The procedure generally began between 9:30 and 10 a.m. The subjects were put in bed and a needle with a cannula attached was inserted in a forearm vein and kept patent with a heparinized saline solution. Heparinized blood samples of 5 cc. each were withdrawn every 15 minutes for three to 45 minutes before and 135 minutes after the administration of either an oral dose of 500 mg. of L-dopa or an intravenous infusion of 0.1 unit/kg. of insulin. The plasma was promptly separated and frozen for subsequent analyses.

The plasma prolactin and GH concentrations were then analyzed by homologous radioimmunoassay techniques (23, 26); the glucose was analyzed by a glucose-oxidase method (27). The GH analyses were sensitive to concentrations as low as 0.5 ng./ml. and the prolactin assays to concentrations as low as 1.0 ng./ml. Prolactin concentrations below 1.0 ng./ml. were arbitrarily assigned values of 0.5 ng./ml.

In accordance with accepted and conservative clinical standards (28), a maximum growth hormone response to hypoglycemia of 6.0 ng. or more was considered adequate; of 5.0 ng. or less, deficient. The same standard was applied to the L-dopa response. All subjects whose baseline growth hormone concentration exceeded 3.0 ng./ml. were excluded. In the insulin response test, subjects were excluded if their baseline blood glucose fell outside the range of 75–120 mg./100cc. or if the maximum fall in blood glucose after the administration of insulin was less than 50 percent of the baseline value (28).

In evaluating the prolactin response to L-dopa it was necessary to develop our own criteria since there are as yet no accepted clinical standards. The mean of all baseline prolactin values and values for up to 45 minutes after L-dopa ingestion were compared with the mean of concentrations achieved between 105 and 135 minutes after

TABLE 1
Growth Hormone and Glucose Responses to Insulin (0.1 unit/kg.)

Subject Number	Sex	GH* (ng./ml.)	Glucose (mg./100 cc.) Baseline	Glucose (mg./100 cc.) Experimental**
Normal subjects (N = 9)				
1	F	17	99	50
2	M	20	80	34
3	M	22	92	36
4	M	6	90	42
5	M	12	107	33
6	M	32	112	34
7	F	6	88	25
8	F	7	89	40
9	M	11	77	32
Mean±S.D.		14.8±8.8	93±11.6	36±7.1
Unipolar depressed patients (N = 8)				
1	F	3	84	40
2	M	4	113	52
3	F	0	112	44
4	F	5	85	33
5	F	22	75	31
6	F	8	113	49
7	F	10	98	40
8	F	4	103	38
Mean±S.D.		7±6.8	98±15	41±7.3
Bipolar depressed patients (N = 5)				
1	M	61	90	40
2	M	21	100	41
3	M	54	98	21
4	M	19	83	31
5	M	9	97	47
Mean±S.D.		33±23.1	94±7	36±10.2

*Maximum growth hormone level after injection of insulin.
**Lowest plasma glucose level after injection of insulin.

L-dopa ingestion. A fall of greater than 50 percent was considered a marked response; a fall of 35–49 percent, a moderate but definite response; and a fall of less than 35 percent, an absent or inadequate response. For the one subject whose baseline prolactin concentrations were less than 1.0 ng./ml. the response could not be evaluated.

RESULTS

Table 1 presents the maximum growth hormone and glucose responses to 0.1 unit/kg. of insulin in the nine normal subjects, eight unipolar depressed patients, and five bipolar depressed patients who had normal baseline GH and glucose concentrations and hypoglycemic responses of greater than 50 percent. All normal subjects and bipolar depressed patients who were tested had drops in blood glucose concentrations of at least 50 percent of baseline values. Of the 16 unipolar depressed patients tested, six had a drop of only 45 to 48 percent and were excluded; this relative insensitivity to insulin in depressive illness has been reported previously (20, 29, 30). Three of the six patients excluded on these grounds failed to have growth hormone responses above 5.0 ng./ml. Two other unipolar depressed patients were excluded because of elevated baseline GH values and one failed to manifest a subsequent GH response,

TABLE 2
Growth Hormone and Prolactin Responses to L-Dopa (500 mg.)

Subject Number	Sex	GH* (ng./ml.)	Prolactin (ng./ml.)** Baseline	Prolactin (ng./ml.)** Experimental***
Normal subjects (N = 20)				
1	F	0	4.9	3.3
5	M	13	1.5	0.5
6	M	36	1.9	0.7
8	F	9	3.9	2.5
9	M	8	4.7	3.1
10	M	0	1.8	0.8
11	M	1	2.7	0.5
12	F	10	1.8	0.5
13	M	13	2.6	1.0
14	M	8	1.4	0.5
15	F	2	4.0	1.7
16	M	18	2.5	0.7
17	M	6	1.7	1.1
18	M	16	5.4	1.6
19	M	8	—	—
20	M	1	4.6	2.6
21	M	18	3.0	2.1
22	M	19	3.9	2.2
23	F	1	2.2	1.0
24	M	3	1.3	0.5
Mean±S.D.		9.8±8.9	2.9±1.3	1.4±1.0
Unipolar depressed patients (N = 19)				
5	F	1	2.3	0.5
6	F	2	2.4	0.5
7	F	5	3.8	2.4
8	F	1	6.4	2.6
9	F	0	2.5	0.5
10	M	3	3.2	4.2
11	F	0	3.2	1.6
12	M	0	2.9	0.5
13	F	0	18.3	10.8
14	F	1	3.0	0.5
15	F	8	2.2	0.7
16	M	18	2.1	1.0
17	M	10	2.8	0.7
18	M	5	2.4	1.2
19	M	0	7.1	6.5
20	F	13	4.5	1.2
21	M	8	0.8	0.5
22	F	1	13.6	7.9
23	F	3	6.6	2.4
Mean±S.D.		4.2±5.1	5.1±4.8	2.4±2.9
Bipolar depressed patients (N = 8)				
1	M	11	2.0	1.3
2	M	16	3.1	0.8
3	M	69	—	—
5	M	6	3.0	2.4
6	M	32	7.8	2.1
7	M	16	4.1	1.2
8	F	2	0.5	0.5
9	F	6	50.0	19.0
Mean±S.D.		19.8±22	10.1±17.8	3.9±6.7

*Maximum growth hormone level after ingestion of L-dopa.
**Mean prolactin concentration.
***Mean concentration at 105 to 135 minutes after ingestion of L-dopa.

All the normal and bipolar depressed subjects had adequate growth hormone responses to hypoglycemia; however, five of the eight unipolar depressed patients failed to have adequate GH responses. The mean maximum growth hormone response of the unipolar depressed group was significantly less than that of either the normal group ($p < .05$, by one-tailed t test) or the bipolar depressed group ($p < .01$, by two-tailed t test).

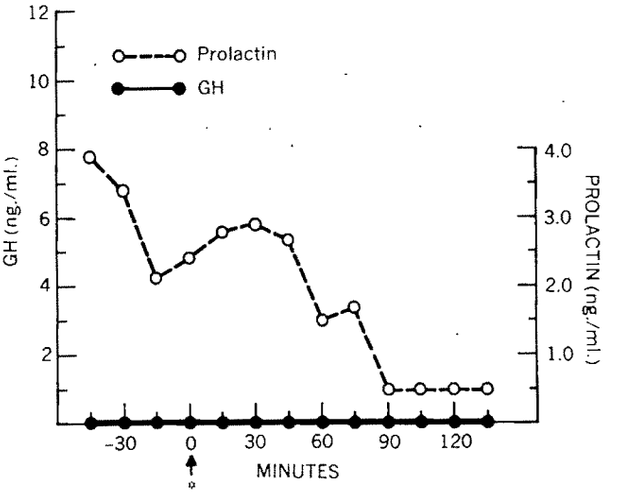
Table 2 presents the growth hormone and prolactin responses to 500 mg. of L-dopa in 20 normal subjects, 19 unipolar depressed patients, and eight bipolar depressed patients (the GH responses of 14 of the normal and 13 of the unipolar depressed subjects were presented in an earlier report [11]). The mean GH response of the unipolar depressed group was significantly less than that of either the normal group ($p < .025$, by one-tailed t test) or the bipolar depressed group ($p < .01$, by two-tailed t test); 65 percent of the normal group and 88 percent of the bipolar depressed group had adequate GH responses, compared with only 26 percent of the unipolar depressed group. There was no significant difference in the GH response of those younger than the mean age and those older than the mean age in any group.

Prolactin responses were measured in 19 of the 20 normal subjects, seven of the eight bipolar depressed patients, and all of the 19 unipolar depressed patients. The mean baseline prolactin concentration was higher for both groups of depressed patients than for the group of normal subjects ($p < .05$, by two-tailed t test). There was no significant difference between normal and depressed subjects in the percentage drop in plasma prolactin after L-dopa ingestion. Nearly all subjects, including those who failed to have an adequate GH response to L-dopa, had a moderate or marked prolactin response; this response began 60 minutes after L-dopa ingestion and reached maximum suppression between 105 and 135 minutes after L-dopa ingestion. Of 14 unipolar depressed patients who failed to secrete GH adequately, 12 manifested moderate or marked suppression of plasma prolactin. Figure 2 illustrates the hormonal responses to L-dopa of a 68-year-old male unipolar depressed patient (subject 12).

A comparison of tables 1 and 2 indicates that of the four unipolar depressed patients who received both the insulin and L-dopa tests, three failed to have an adequate GH response to L-dopa but did have an adequate GH response to insulin-induced hypoglycemia, and one failed to respond to either test.

FIGURE 2

Growth Hormone and Prolactin Responses of a Unipolar Depressed Patient to 500 mg. of L-Dopa



*The L-dopa was administered at this time.

DISCUSSION

We believe the data we have presented here support the evidence that there exists a central neurochemical disturbance (probably involving catecholamines) in unipolar depressive illness that differs from the disturbance found in bipolar depressive illness. In response to both hypoglycemia and the ingestion of L-dopa, unipolar depressed patients had significantly lower GH responses than normal subjects and bipolar depressed patients. The differences in GH responses of the bipolar and unipolar depressed patients to L-dopa are consistent with the psychopharmacological finding that most bipolar depressed patients become manic while receiving high doses of L-dopa, whereas unipolar depressed patients do not (31). Furthermore, in view of the fact that brain catecholamines regulate GH release, it is interesting to note that the activity of platelet monoamine oxidase, which catabolizes catecholamines, has been shown to be low in young adults, high in middle-aged subjects, higher yet in unipolar depressed patients, but low in bipolar depressed patients (32–34)—responses that inversely parallel the mean GH responses to L-dopa in these groups (14).

These endocrine responses prompt speculation about the nature of the neurochemical disturbance in unipolar depressions. Nearly all of the unipolar depressed patients who failed to release GH in response to L-dopa did manifest prolactin suppression. If GH release is indeed regulated by norepinephrine and if prolactin inhibition is regulated by dopaminergic neurons, our data would suggest that the dose of L-dopa reached the brain and was converted to dopamine but failed to generate a noradrenergic GH response. Possible explanations for such a reaction might include a defect in the conversion of dopamine to norepinephrine by dopamine B-hydroxylase, increased catabolism of norepinephrine by monoamine oxidase, or an insensitivity of noradrenergic receptors, among other possibilities. If, however, GH release is primarily regulated by dopamine, the differences between GH and prolactin responses suggest a disturbance in the dopaminergic pathways that selectively affects the neuroendocrine cells that secrete growth-hormone-releasing factor.

The tendency for depressed patients to have higher baseline prolactin concentrations than normal subjects is

probably due to the emotional stress associated with the illness, since stress has been shown to stimulate prolactin secretion (35); it is conceivable, however, that increased prolactin concentrations might reflect depleted levels of dopamine in some depressed patients.

It is premature, however, to draw firm neurochemical conclusions from these data. For example, an idiosyncrasy of absorption or peripheral metabolism of L-dopa by unipolar depressed patients might account for their reduced growth hormone responses: a low plasma level of L-dopa might be sufficient to trigger a prolactin response but insufficient to stimulate the release of GH. The fact that a similar variation was noted in the GH response of unipolar depressed patients to hypoglycemia makes this possibility less likely, although the diminished GH responses of the eight unipolar depressed patients to hypoglycemia might be due to the slightly lesser degree of hypoglycemia achieved by this group.

It should also be noted that the groups we studied were unequally distributed in regard to sex and that most of the unipolar depressed patients were postmenopausal women. Previous reports indicate that women tend to have more marked GH responses to a variety of stimuli than do men (36), which would lend even greater significance to the diminished GH responses we have noted in unipolar depressed women. However, the effect of menopause on GH responses has not yet been reported. Our preliminary studies with a small group of normal women suggest that the menopause may indeed be associated with reduced GH responses to L-dopa, although depressed postmenopausal women appear to secrete even less GH than normal postmenopausal women. Further studies with a larger group of subjects are in progress to clarify these points.

Above all, the complexities of interactions among the various hypothalamic neurotransmitters—catecholaminergic, indoleaminergic, and cholinergic (19, 37)—make a simple neurochemical formulation of the differing GH responses impossible at this time. Nevertheless, it appears that the examination of neuroendocrine responses may well be of value in the study of hypothalamic functioning in affective disorders.

REFERENCES

1. Anton-Tay F, Wurtman RJ: Brain monoamines and endocrine function, in Frontiers in Neuroendocrinology. Edited by Martini L, Ganong WF. New York, Oxford University Press, 1971, pp 45–66
2. Kamberi IA, Mical RS, Porter JC: Effect of anterior pituitary perfusion and intraventricular injection of catecholamines on prolactin release. Endocrinology 88:1012–1020, 1971
3. Meites J, Lu KH, Wuttke W, et al: Recent studies on function and control of prolactin secretion in rats. Recent Prog Horm Res 28:471–526, 1972
4. Kleinberg DL, Noel GL, Frantz AG: Chlorpromazine stimulation and L-dopa suppression of plasma prolactin in man. J Clin Endocrinol Metab 33:873–876, 1971
5. Brown G, Reichlin S: Psychologic and neural regulation of growth hormone secretion. Psychosom Med 34:45–61, 1972
6. Toivola PTK, Gale CC: Stimulation of growth hormone release by microinjection of norepinephrine into hypothalamus of baboons. Endocrinology 90:895–902, 1972
7. Müller EE, Dal Pra P, Pecile A: Influence of brain neurohumors injected into lateral ventricles of the rat on growth hormone secretion. Endocrinology 83:893–896, 1968
8. Müller EE, Pecile A, Felici M, et al: Norepinephrine and dopamine injection into lateral brain ventricles of the rat and growth hormone releasing activity in hypothalamus and plasma. Endocrinology 86:1376–1382, 1970
9. Lal S, De la Vega CE, Sourkes TL, et al: Effect of apomorphine on human growth hormone secretion. Lancet 2:661, 1972
10. Malarkey WB, Jacobs LS, Daughaday WH: Levodopa suppression of prolactin in nonpuerperal galactorrhea. N Engl J Med 285:1160–1163, 1971
11. Friesen H, Guyda H, Hwang P, et al: Functional evaluation of prolactin secretion: a guide to therapy. J Clin Invest 51:706–709, 1972
12. Boyd AE, Lebovitz B, Pfeiffer B: Stimulation of human growth hormone secretion by L-dopa. N Engl J Med 283:1425–1429, 1970
13. Kansal PC, Buse J, Talbert OR, et al: Effect of L-dopa on plasma growth hormone, insulin, and thyroxine. J Clin Endocrinol Metab 34:99–105, 1972
14. Sachar EJ, Mushrush G, Perlow M, et al: Growth hormone responses to L-dopa in depressed patients. Science 178:1304–1305, 1972
15. Miller EE, Sawano S, Arimura A: Blockade of release of growth hormone by brain norepinephrine depletors. Endocrinology 80:471–476, 1967
16. Blackard WG, Heldingsfelder SA: Adrenergic receptor control mechanism for human growth hormone secretion. J Clin Invest 47:1407–1414, 1968
17. Toivola PTK, Gale CC, Goodner CJ, et al: Central alpha adrenergic regulation of growth hormone and insulin. Hormones 3:193–213, 1972
18. Schildkraut JJ: Neuropharmacology and the Affective Disorders. New York, Little Brown and Co, 1970
19. Davis JM: Theories of biological etiology of affective disorders. Int Rev Neurobiol 12:145–175, 1970
20. Sachar EJ, Finkelstein J, Hellman L: Growth hormone responses in depressive illness: response to insulin tolerance test. Arch Gen Psychiatry 24:263–269, 1971
21. Mueller PS, Heninger GR, MacDonald RK: Studies on glucose utilization and insulin sensitivity in affective disorders, in Recent Advances in Psychobiology of Depressive Illnesses. Edited by Williams TA, Katz MM, Shield JA. Washington, DC, US Department of Health, Education, and Welfare, 1972, pp 235–248
22. Carroll BJ: Studies with hypothalamic pituitary-adrenal stimulation tests in depression, in Depressive Illness: Some Research Studies. Edited by Davies B, Carroll BJ, Mowbray RM. Springfield, Ill, Charles C Thomas, 1972, pp 149–201
23. Frantz AG, Kleinberg DL, Noel GL: Studies on prolactin in man. Recent Prog Horm Res 28:527–573, 1972
24. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 23:56–62, 1960
25. Rosenthal S, Klerman G: Content and consistency in the endogenous depressive pattern. Br J Psychiatry 112:471–484, 1966
26. Laue K, Gottlieb C, Herbert V: Preliminary report on coated charcoal immunoassay of human chorionic "growth hormone-prolactin" and growth hormone. Proc Soc Exp Biol Med 22:126–131, 1966
27. Washko ME, Rice EW: Determination of glucose by an improved enzymatic procedure. Clin Chem 7:542–545, 1962
28. Raiti S, Davis WT, Blizzard RM: Comparison of effects of insulin hypoglycemia and arginine infusion on release of human growth hormone. Lancet 2:1182–1184, 1967
29. Mueller PS, Heninger GR, MacDonald RK: Insulin tolerance test in depression. Arch Gen Psychiatry 21:587–594, 1969
30. Carroll BJ: Hypothalamic pituitary function in depressive illness: insensitivity to hypoglycemia. Br Med J 3:27–28, 1969
31. Murphy DL, Brodie HKH, Goodwin FK, et al: Regular induction of hypomania by L-dopa in "bipolar" manic depressive patients. Nature 229:135–136, 1971
32. Robinson DS, Davis JM, Nies A, et al: Ageing, monoamines, and monoamino-oxidase levels. Lancet 1:290–291, 1972
33. Nies A, Robinson DS, Raveris CL, et al: Amines and monoamine oxidase in relation to aging and depression in man. Psychosom Med 33:470, 1971

34. Murphy DL, Weiss R: Reduced monoamine oxidase activity in blood platelets from bipolar depressed patients. Am J Psychiatry 128:1351–1357, 1972
35. Noel GL, Suh HK, Stone JG, et al: Human prolactin and growth hormone release during surgery and other conditions of stress. J Clin Endocrinol Metab 35:840–851, 1972
36. Frantz AG, Rabkin MT: Effects of estrogen and sex difference on secretion of human growth hormone. J Clin Endocrinol Metab 25:1470–1480, 1965
37. Janowsky DS, El-Yousef MK, Davis JM, et al: A cholinergic-adrenergic hypothesis in mania and depression. Lancet 2:632–635, 1972

Plasma Binding of Imipramine and Clinical Outcome

BY ALEXANDER H. GLASSMAN, M.D., MARIA J. HURWIC, PH.D., AND JAMES M. PEREL, PH.D.

The binding of imipramine to plasma protein was examined in 26 depressed patients. In contrast to the findings of previously published reports, the fraction of the drug that remained unbound was found to vary significantly from one patient to another. This finding provides a possible explanation for the discrepancies that have been found in studies that have attempted to correlate plasma levels of antidepressant drugs and clinical outcome.

THE IMPORTANCE of relating the clinical effects of drugs to measurements of blood (or plasma) levels, rather than to the dosage of the drugs, was clearly demonstrated with antimalarial compounds as early as 1945 (1). The advances in chemical analytical methods in the past 12 years have led to a considerable number of studies that correlated blood levels with clinical response. Data from studies of anticonvulsants (2, 3), digitalis glycosides (4), and anticoagulants (5, 6) have convincingly shown that blood levels are a much more accurate indicator and predictor of clinical effects than is dose regimen.

In the last several years it has become apparent that identical oral doses (mg./kg.) of a tricyclic antidepressant can result in radically different blood levels in different individuals (7). The obvious question this raises is: What impact does this variability in blood levels have on clinical outcome? This question has turned out to be more complex than it first appeared.

Read at a New Research session at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

The authors are with the Department of Biological Psychiatry, New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032, where Dr. Glassman is Acting Director, Dr. Hurwic is Senior Research Scientist, and Dr. Perel is Associate Research Scientist and Laboratory Chief.

This work was supported in part by Public Health Service grants MH-17044 and MH-21133 from the National Institute of Mental Health.

To date, three different groups of researchers have attempted to examine the problem in four separate studies. Braithwaite and associates (8) in England have demonstrated a simple linear relationship between increasing plasma levels of a tricyclic drug and increasing clinical improvement. Asberg and her associates (9, 10) in two separate studies have found a curvilinear relationship, with poor response at both low and high plasma levels and a good response only at intermediate values. Meanwhile, Burrows, Davies, and Scoggins (11) in Australia examined the same question and found no significant correlation between plasma level and clinical response. The question now becomes not only which group is right but why there is so much disagreement.

One assumption crucial to all of these studies was that the fraction of tricyclic drugs bound to plasma proteins could be treated as a constant. This assumption was based on the work of Borga and his associates (12). For several reasons it seems necessary to reexamine this assumption.

Among a large number of therapeutic agents a considerable fraction of the ingested drug is bound strongly to plasma proteins (primarily plasma albumin) and, in this state, is not pharmacologically active. This binding is readily reversible and is not specific. The mechanism that underlies binding is not completely understood, but it depends on electrostatic attraction and also on lipid solubility. Drugs vary considerably in their affinity for protein binding. The most important point is that this biochemical process can affect the distribution, rate of metabolism, and pharmacological activity of a compound (13).

Tricyclic antidepressants have been reported to be 90 to 95 percent bound to plasma protein. It is now clear from work with a number of different drugs that only the unbound fraction of a drug is pharmacologically active (14, 15). Therefore, the activity of an antidepressant drug of this class is dependent on the rather small fraction of it that remains free in the blood. As a result, small shifts in the bound fraction, while not proportionately

TABLE 1
Example of Data Collected from One Patient (a 54-Year-Old Woman)

Date of Sample	Percentage of Drug Bound to Protein	Protein (mg./100 ml.)	Recovery (Percentage)
11/27/72	81.0	7.0	90.6
	81.8		93.0
12/13/72	81.7	7.6	86.4
	81.5		86.4
12/20/72	82.2	7.0	91.1
	83.6		91.3
12/26/72	80.2	6.9	89.6
	80.6		89.5
12/27/72	81.8	7.0	91.7
	83.0		92.7

large, can produce significant alterations in the percentage of free drug. A variation of five percent above or below an average binding of 90 percent would give the bound drug a maximum range of 85 to 95 percent. This would mean that the active fraction of the drug could vary from five to 15 percent—a not insignificant difference.

Another concern we had was that the measurements used in the original studies on binding involved several questionable procedures—the most obvious being the use of room temperature rather than body temperature in performing the analyses. It is well known that decreasing the temperature increases the binding (16), and there seems no reason to assume that the fractions of the drug that are free and bound would be the same at 26C as they are at 37C.

METHOD

To study the binding of tricyclic antidepressant drugs to plasma protein, multiple blood samples were taken from 26 consecutively admitted depressed patients who were being treated with imipramine. These samples were examined by means of equilibrium dialysis, as originally described by Perel and associates (17). All blood samples were divided and subjected to duplicate analyses, which were performed at 37C (body temperature). The overall amount of imipramine recovered in each sample was measured, as well as the total amount of plasma proteins. For the entire group of 26 patients, 134 binding samples were analyzed.

RESULTS

Table 1 shows the data collected for one patient, a 54-year-old woman. The precision between duplicate samples for this patient was better than ±0.5 percent. The precision between duplicate samples for the group as a whole was also better than ±0.5 percent; the intraclass correlation coefficient was 0.92.

The average amount of imipramine bound patients was 85.7 percent, with a standard deviation 3.7. The variance in binding among patients was 21.0 percent; within individual patients the average variance among repeated samples was 1.8 percent. When these variances were compared, an F value greater than ten was obtained.

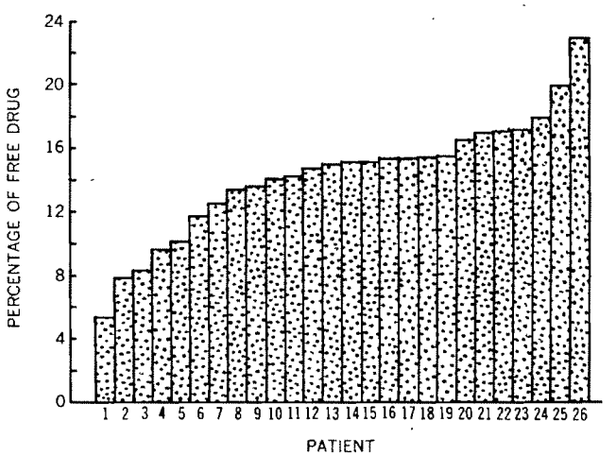
Figure 1 shows the variability among the 26 patients in the percentage of free imipramine in the plasma. The accuracy of this determination depended mainly on the accuracy of the measurement of the bound fraction. The range in the fraction of free drug among all patients was 5.4 percent to 23 percent.

CONCLUSIONS

These results show that it is possible to measure with high reproducibility the binding of tricyclic drugs to plasma protein at body temperature by equilibrium dialysis. This method produced results that agreed with those of previous reports that found a low degree of variability in the levels of plasma binding in individual patients on repeated samplings. However, the absolute values reported here are significantly different from those previously published. Borga's group reported that imipramine was 95 percent bound when measured at room temperature. The value for binding at body temperature fell to 85 percent—as might have been predicted.

Our most striking observation, however, was that the plasma binding of imipramine was not constant from one patient to another. This also is in contrast to previous reports. Our results show that there can be a more than fourfold difference (5.4 to 23 percent) in the amount of free drug available to different patients. In the four previous studies we mentioned on plasma drug levels and clinical outcome (8–11), the variation found in steady-

FIGURE 1
Variation Among Patients in Percentage of Free Imipramine in Plasma (N=26)



state plasma concentrations[1] of the total drug (bound and unbound fractions) during chronic drug administration ranged from fivefold to 20-fold. According to the results of our study, the effect on clinical outcome of these apparent differences in steady-state plasma concentrations of the total drug could be compounded by individual differences in the amount of the drug that is bound. This could account for some of the discrepancies seen in studies that have attempted to correlate plasma levels of tricyclic antidepressants and clinical response. Whether this is the correct explanation is a complicated issue that involves the drug's apparent volume of distribution and its binding to tissue (18). A final judgment on the matter must therefore await further study.

REFERENCES

1. Shannon JA: The study of antimalarials and antimalarial activity in the human malarias. Harvey Lect 41:43–89, 1945
2. Buchtal F, Svensmark O, Schiller PJ: Clinical and electroencephalographic correlation with serum levels of diphenylhydantoin. Arch Neurol 2:624–630, 1960
3. Kutt H, McDowell F: Management of epilepsy with diphenylhydantoin sodium. JAMA 203:969–972, 1968
4. Smith TW, Haber E: The clinical value of serum digitalis glycoside concentrations in the evaluation of drug toxicity. Ann NY Acad Sci 179:322–337, 1971
5. Dayton PG, Tarcan Y, Chenkin T, et al: The influence of barbiturates on coumarin plasma levels and prothrombin response. J Clin Invest 40:1797–1802, 1961
6. O'Reilly RA, Aggeler PM: Determinants of the response to oral anticoagulant drugs in man. Pharmacol Rev 22:36–96, 1970
7. Glassman AH, Perel JM: The clinical pharmacology of imipramine. Arch Gen Psychiatry 28:649–653, 1973
8. Braithwaite RA, Goulding R, Baily J, et al: Plasma concentration of amitriptyline and clinical response. Lancet 1:1297–1300, 1972
9. Asberg M, Cronholm B, Sjöqvist F, et al: Relationship between plasma level and therapeutic effect of nortriptyline. Br Med J 3:331–334, 1971
10. Kragh-Sorenson P, Asberg M, Eggert-Hansen C: Plasma nortriptyline levels in endogenous depression. Lancet 1:113–115, 1973
11. Burrows GD, Davies B, Scoggins BA: Plasma concentration of nortriptyline and clinical response in depressive illness. Lancet 2:619–623, 1972
12. Borga O, Azarnoff DL, Forshell GP, et al: Plasma protein binding of tricyclic antidepressants in man. Biochem Pharmacol 18:2135–2143, 1969
13. Dayton PG, Israili ZH, Perel JM: Influence of binding on drug metabolism and distribution. Ann NY Acad Sci (in press)
14. Anton AH: The relation between the binding of sulfonamides to albumin and their antibacterial efficacy. J Pharmacol Exp Ther 129:282–290, 1960
15. Brodie BB: Displacement of one drug by another from carrier or receptor sites. Proc R Soc Med 58 (11, part II): 946–955, 1965
16. Van Der Kleijn E: Protein binding and lipophilic nature of ataractics of the meprobamate and diazepine group. Arch Int Pharmacodyn 179:225–250, 1969
17. Perel JM, Snell MM, Chen W, et al: A study of structure-activity relationships in regard to species differences in the phenylbutazone series. Biochem Pharmacol 13:1305–1317, 1964
18. Curry SH: Theoretical changes in drug distribution resulting from changes in binding to plasma proteins and to tissue. J Pharm Pharmacol 22:753–757, 1970

[1] Chronic treatment with the same daily doses of imipramine leads to a gradual accumulation of the drug in the patient's body. After oral administration most of the ingested drug is rapidly removed initially from the blood and distributed into various tissue stores; a fixed percentage of the fraction that is presented to the liver is metabolized and subsequently eliminated. As tissue stores undergo an accumulation of the antidepressant the levels of the drug in the plasma increase, so that the absolute amount metabolized and excreted also increases. Eventually, at therapeutic dosage levels, these processes balance one another, and an apparent constant value, or "steady-state" plasma concentration, is usually attained.

Antagonistic Effects of Physostigmine and Methylphenidate in Man

BY DAVID S. JANOWSKY, M.D., M. KHALED EL-YOUSEF, M.D., JOHN M. DAVIS, M.D., AND H. JOSEPH SEKERKE, PH.D.

The authors describe the antagonistic effects of physostigmine, a centrally acting acetylcholinesterase inhibitor, and methylphenidate, an amphetamine-like stimulant, on manic and schizophrenic patients. In both patient groups, physostigmine increased behavioral inhibition and decreased behavioral activation; patients displayed symptoms that are characteristic of psychomotor inhibition. Methylphenidate had the opposite effect of increasing activation and decreasing inhibition. Treatment with each drug antagonized the effects of the other. In the schizophrenic patients, physostigmine prevented and reversed the methylphenidate-induced symptoms of psychosis. In manic patients, physostigmine decreased and methylphenidate increased manic symptoms.

IT IS WELL KNOWN that a balance between cholinergic and adrenergic factors regulates such somatic functions as heart rate, gastric motility and tone, and pupillary size (1). There is also a great deal of indirect evidence suggesting that antagonistic adrenergic and cholinergic systems exist in the central nervous system (CNS) (2–4), that they are significant in the functioning of the CNS, and that these systems regulate certain forms of behavior (2). For example, it is reported that an increase in central cholinergic activity causes a decrease in self-stimulation (5–7), conditioned behavior of a number of types including avoidance (8), and locomotor activity (9); all of these are activated by an increase in adrenergic activity in the CNS (10). Recently, methylphenidate-induced increases in locomotor activity and stereotyped gnawing behavior were shown to be antagonized or prevented by physostigmine, a cholinesterase inhibitor that is active in the CNS, but not by neostigmine, a peripherally active cholinesterase inhibitor (11). Subthreshold doses of atropine, which do not themselves produce a behavioral response, given together with subthreshold doses of amphetamine were reported to act in synergism to produce avoidance responses in rats (2); amphetamine and anticholinergic agents were also reported to act in synergism to affect locomotor activity in mice (2).

These studies indicate that there are probably a number of different neuronal pathways in the CNS that are controlled by interlocking and/or antagonistic cholinergic and dopaminergic or noradrenergic systems. The purpose of this study is to describe the behavioral effects that are produced in man by gross pharmacological alterations of the adrenergic and cholinergic systems. There has been relatively little work done on the effect on human behavior of stimulating cholinergic sites in the CNS (12, 13) and, to our knowledge, no previous work on the effects on human behavior of the antagonism of the adrenergic and cholinergic systems. We have previously demonstrated that physostigmine, a centrally acting cholinesterase inhibitor, decreases manic symptoms, presumably by increasing the concentrations of acetylcholine at CNS synapses, thereby antagonizing the increased activity of the CNS adrenergic system that is thought to occur in manic subjects (4, 12). We have also noted that methylphenidate, an amphetamine-like stimulant, administered intravenously, increases ratings for psychosis and interaction in actively ill schizophrenics and ratings for interaction in normal subjects (14). This presumably occurs because methylphenidate increases the functional availability of norepinephrine and/or dopamine in the CNS by its ability to release and to block the uptake of monoamines (15).

The norepinephrine hypothesis of mania and depression (4) and the dopamine hypothesis of schizophrenia (14) are currently among the most vigorously investigated hypotheses about the etiology of these disorders. The experiments we shall report provide data that are directly relevant to the substantiation of these hypotheses. Since it is known that many antagonisms between norepinephrine and/or dopamine and acetylcholine occur in the CNS, the study of behavior following increases in functional concentrations of acetylcholine in the synapse will provide information that is relevant to the understanding of depression, mania, and schizophrenia. Similarly, since methylphenidate presumably exerts its behavioral effects by releasing dopamine and norepinephrine in the CNS, its effects on behavior in these diagnostic categories is of theoretical interest. However, it should be noted that

Read at the 126th annual meeting of the American Psychiatric Association, Honolulu, Hawaii, May 7–11, 1973.

At the time this work was done, the authors were with the Vanderbilt University School of Medicine, Nashville, Tenn., where Dr. Janowsky was Associate Professor of Psychiatry and Assistant Professor of Pharmacology, Dr. El-Yousef is Assistant Professor of Psychiatry and Pharmacology, Dr. Davis was Professor of Psychiatry and Associate Professor of Pharmacology, and Dr. Sekerke is Instructor of Pharmacology. Dr. Janowsky is now Associate Professor, Department of Psychiatry, School of Medicine, University of California at San Diego, P.O. Box 109, La Jolla, Calif. 92037. Dr. Davis is now Professor of Psychiatry, University of Chicago School of Medicine, and Director of Research, Illinois State Psychiatric Institute, Chicago, Ill.

This work was supported in part by Public Health Service grants GH-15431 from the National Institute of General Medical Sciences and MH-11468 from the National Institute of Mental Health and by research funds from the Tennessee Department of Mental Health. The work was done at the Tennessee Neuropsychiatric Institute, Nashville, Tenn.

methylphenidate and physostigmine are not polar opposites; they have entirely different biological and pharmacological properties and exert effects on different but antagonistic systems. We have used them in these experiments as psychobiological investigative tools.

In order to explain the antagonistic effects of methylphenidate and physostigmine on each other, we shall first describe the specific behavioral effects of each drug alone as well as those of neostigmine (5), which was used in this instance as a control (experiment A). We shall then describe how physostigmine counteracts the behavioral effects of methylphenidate in subjects given methylscopolamine as a pretreatment (experiment B), and, conversely, how methylphenidate counteracts physostigmine's behavioral effects (experiment C).

GENERAL METHOD

The subjects were 12 manic and 24 actively ill schizophrenic patients. Not all were included in every experiment. The diagnoses were agreed upon by three psychiatrists in accordance with the criteria given in the APA *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-II*) (16).

On the basis of data gathered in a pilot study of normal, schizophrenic, and manic subjects, we noted that physostigmine exerted certain "anergic-inhibitory" effects that appeared to cross diagnostic categories. We noted that physostigmine caused emotional withdrawal, lethargy, irritability, apathy, drained feelings, retardation, and tiredness. In contrast, we noted that methylphenidate caused a psychic "activation" that was characterized by an increase in talkativeness, in the number of interactions, and in the range and speed of thinking. We therefore developed a series of scales scored from 0 to 5 to reflect the behavior of the subjects, regardless of their diagnosis.

An inhibition scale consisted of the following items: lethargy, slowness of thought, wanting to say nothing, withdrawal, apathy, depression, lack of energy, feeling drained, hypoactivity, absence of thought, motor retardation, and emotional withdrawal; the sum of these items constituted the inhibition score. Similarly, an activation scale was constructed that included the following items: cheerfulness, friendliness, degree of interaction, and talkativeness; the sum of these ratings constituted the activation score. In addition, all patients were rated for irritability, dysphoria, hostility, anger, wanting to be alone, crying, sadness, sleepiness, unusual thought content, conceptual disorganization, and blunted affect.

Manic patients were also rated by means of a manic intensity scale. The scale was a modification of the Beigel-Murphy Manic-State Rating Scale (17) and included 11 items that were thought by Beigel and Murphy to best characterize the severity of manic symptoms. The Beigel-Murphy elation-grandiosity subscale was also used to evaluate each manic patient. Schizophrenic patients were rated on the degree of their psychosis, using a modification of the Bunney-Hamburg rating system (18). In each case, the score was the sum of the individual item ratings.

In each of the following experiments, ratings were made every ten minutes by a nurse-rater who, like the patient, did not know whether the patient was receiving physostigmine, methylphenidate, or the control agent, neostigmine, or whether the patient was receiving one of these active agents or a placebo.

EXPERIMENT A: EFFECTS OF PHYSOSTIGMINE, NEOSTIGMINE, AND METHYLPHENIDATE

Method

Following two or more doses of placebo, given at five-minute intervals by means of an intravenous infusion device, manic and schizophrenic patients received one of the following treatments: 1) 0.5 mg./kg. of methylphenidate; 2) 0.25 mg. of neostigmine every five minutes until a total dose of 1.25 mg. had been given; or 3) 0.5 mg. of physostigmine every five minutes until a total dose of 2.50 mg. had been given or until inhibition occurred. Those patients who received physostigmine or neostigmine had been given an intramuscular injection of 1.0 mg. of methylscopolamine before the initial placebo injection. (Methylscopolamine is an anticholinergic drug that is active only in the peripheral nervous system.) After injection of the active drug, they received placebo injections every five minutes for 30 minutes. Those patients who received methylphenidate had been given an intramuscular injection of placebo before the initial placebo treatment; after treatment with methylphenidate, they were given injections of placebo every five minutes for 45 minutes.

Double-blind ratings of the patients' behavior were performed in the manner described above. Baseline ratings taken during the initial placebo phase and ratings taken after the active drug had been administered were compared by means of Student's one-tailed t test for paired observations.

Results

Schizophrenic patients. Table 1 presents data on the effects of neostigmine, physostigmine, and methylphenidate on the behavior of the schizophrenic patients. Neostigmine did not significantly change the schizophrenic group's inhibition scale or activation scale ratings.

Physostigmine significantly increased the schizophrenic patients' scores on the inhibition scale and decreased their scores on the activation scale. However, physostigmine did not significantly affect the schizophrenic group's psychosis rating. Nevertheless, all patients who received physostigmine became more lethargic, drained, and hypoactive, although their delusions and bizarre behavior generally persisted in muted or subdued form. After receiving physostigmine, the schizophrenic patients showed an increase in their ratings for dysphoria.

In contrast, methylphenidate decreased scores on the

TABLE 1
Effects of Physostigmine, Methylphenidate, and Neostigmine on Schizophrenic Patients

Item	Change Score*		
	Physostigmine (N=8)	Methylphenidate (N=13)	Neostigmine (N=6)
Inhibition scale	6.93±1.81**	−1.95± .98***	−.48±2.29
Lethargy	1.23± .22***	− .49± .19***	−.18± .20
Slowness of thoughts	.48± .30	− .12± .08	.02± .19
Wanting to say nothing	.34± .17***	− .06± .21	−.22± .24
Withdrawal	.58± .28***	− .32± .17***	−.15± .24
Apathy	.30± .28	− .29± .15***	−.25± .29
Lacking energy	.75± .30***	− .12± .08	.27± .36
Feeling drained	.91± .33***	− .19± .11***	.23± .35
Hypoactivity	.99± .29**	− .36± .15***	.08± .05
Lack of thoughts	.43± .29	.10± .25	−.23± .19
Depression	.23± .48	.12± .15	.00± .43
Motor retardation	1.16± .27**	− .34± .18***	−.23± .35
Emotional withdrawal	.46± .31	− .83± .23**	−.73± .48
Activation scale	−2.31±1.03***	1.72± .85***	.68±1.41
Cheerfulness	−.35± .21	− .30± .28	.17± .38
Friendliness	−.60± .25***	− .14± .30	.10± .30
Interaction	−.69± .37	1.13± .27†	.00± .30
Talkativeness	−.68± .40	1.02± .25†	.10± .31
Other ratings			
Irritability	−.33± .39	.10± .14	−.17± .18
Dysphoria	1.01± .49***	.15± .17	.03± .45
Hostility	−.26± .17	.23± .19	.03± .03
Anger	−.24± .17	.24± .21	.10± .10
Desire to be alone	.18± .23	− .18± .14	−.03± .23
Crying	.10± .23	.28± .15***	.17± .17
Sadness	.23± .41	.36± .20	.15± .45
Sleepiness	1.08± .66	− .12± .16	.18± .34
Psychosis	.08± .41	1.04± .25†	−.68± .30
Unusual thought content	.11± .27	.96± .23†	−.70± .31***
Conceptual disorganization	.28± .25	1.06± .26†	−.28± .38

* The change score, plus or minus the standard error of the mean, equals the difference between the ratings that were taken during the baseline-placebo phase and those taken during the posttreatment phase.
** $p < .01$.
*** $p < .05$.
† $p < .001$.

inhibition scale and a number of its items and increased scores on the activation scale. In addition, scores for items that referred to the level of psychosis, including unusual thought content, conceptual disorganization, and psychosis, were significantly increased by methylphenidate. This increase in psychosis was pronounced, persisted for one or more hours, and was consistent with previously reported findings (14).

Manic patients. Table 2 gives comparable data for the manic patient group. Physostigmine increased the manic patients' scores on the inhibition scale and ratings for dysphoria. Methylphenidate, on the other hand, increased scores on the activation scale, but did not significantly increase ratings of psychosis, although increases in these ratings were noted for some patients.

Generally speaking, physostigmine decreased and methylphenidate increased manic symptoms. Table 2 shows that physostigmine decreased the patients' scores on the Beigel-Murphy manic intensity scale and ratings for certain items in the mania rating scale, while methylphenidate caused a significant increase in ratings for this scale, as well as for certain items. Physostigmine and methylphenidate thus produced opposite effects on the ratings of the Beigel-Murphy scale items that assessed the manic state. Neostigmine did not significantly alter the psychological state of the manic patients.

TABLE 2
Effects of Physostigmine, Methylphenidate, and Neostigmine on Manic Patients

Item	Change Score*		
	Physostigmine (N=9)	Methylphenidate (N=6)**	Neostigmine (N=9)
Activation scale	−3.30± .44***	2.87± .60†	−.20± .78
Inhibition scale	13.77±4.33†	− .55± .45	−.31±1.54
Lethargy	1.08± .23***	− .03± .03	−.02± .34
Slowness of thoughts	.67± .26††	.00± .00	.04± .03
Wanting to say nothing	.84± .24†	.00± .00	−.03± .14
Withdrawal	1.20± .25***	.00± .00	−.06± .08
Apathy	.52± .21††	.00± .00	−.16± .14
Lacking energy	.95± .20***	− .07± .07	−.07± .18
Feeling drained	1.20± .21***	− .13± .13	−.01± .21
Hypoactivity	1.14± .23***	− .03± .03	−.04± .36
Lack of thoughts	.17± .09††	.00± .00	−.03± .03
Depression	1.02± .25†	− .23± .20	.12± .14
Psychomotor retardation	1.18± .23***	− .03± .03	−.06± .23
Emotional withdrawal	.50± .26††	− .03± .03	−.30± .78
Beigel-Murphy mania ratings			
Talkativeness	−1.33± .32***	1.20± .18***	−.17± .30
Irritability	.25± .45	.53± .60	.02± .39
Activity	−1.06± .25***	.82± .24†	.04± .26
Flighty-mindedness	−1.05± .29†	1.10± .38††	.34± .41
Happiness	−1.33± .29***	.05± .31	.12± .27
Grandiosity	− .22± .19	.57± .34	−.17± .30
Manic intensity score	−6.59±1.80†	5.55± .18***	.19±2.87
Elation-grandiosity score	−1.81± .43***	1.13± .91	.41± .25
Other			
Dysphoria	.69± .36††	− .02± .07	−.08± .23
Crying	.21± .10††	.48± .41	−.03± .03
Sadness	1.03± .27†	− .07± .43	.07± .17
Psychosis	− .08± .18	.37± .42	.11± .34

* The change score, plus or minus the standard error of the mean, equals the difference between ratings that were taken during the baseline-placebo phase and those taken during the posttreatment phase.
** N=6 for the activation and inhibition scales; for the Beigel-Murphy ratings, the manic intensity score, the elation-grandiosity score, and the "other" category, N=12.
*** $p < .001$.
† $p < .01$.
†† $p < .05$.

TABLE 3
The Antagonism of the Effects of Methylphenidate by Physostigmine in Seven Schizophrenic Patients

Item	Stages of Experiment		
	Baseline and Placebo	Administration of Methylphenidate	Administration of Physostigmine
Inhibition scale	5.53±2.73	1.10±0.57*	5.77±1.92*
Activation scale	6.51±1.13	8.37±0.68	5.63±1.00*
Cheerfulness	1.07±0.47	0.69±0.33	0.14±0.14*
Friendliness	1.73±0.36	1.50±0.39	1.23±0.40
Interaction	1.91±0.27	3.19±0.16**	2.19±0.37***
Talkativeness	1.80±0.24	3.00±0.07**	2.07±0.33*
Other			
Irritability	0.47±0.29	0.54±0.35	0.86±0.32
Depression	0.43±0.30	0.43±0.28	0.96±0.46*
Psychosis	2.21±0.54	3.40±0.46**	2.67±0.52**
Emotional withdrawal	1.56±0.50	0.70±0.30*	0.96±0.44
Conceptual disorganization	1.74±0.67	2.89±0.63***	2.39±0.63***
Unusual thought content	1.99±0.57	3.43±0.49**	2.61±0.56***
Blunted affect	1.84±0.57	0.99±0.38*	1.07±0.41

* The difference between this rating and that in the preceding column is significant, $p < .05$.
** The difference between this rating and that in the preceding column is significant, $p < .001$.
*** The difference between this rating and that in the preceding column is significant, $p < .01$.

EXPERIMENT B: ANTAGONISM OF METHYLPHENIDATE'S EFFECTS BY PHYSOSTIGMINE

Method

Following two or more doses of placebo, given, as in experiment A, at five-minute intervals by means of an intravenous infusion device, seven schizophrenic and five manic patients received 0.5 mg./kg. of methylphenidate over a period of 30 seconds, followed by two additional doses of placebo. After this, the patients received injections of one of the following: 1) placebo, administered every five minutes; 2) 0.5 mg. of physostigmine, administered every five minutes until a total 2.5 mg. had been given or the drug had antagonized the effects of methylphenidate; or 3) 0.25 mg. of neostigmine, administered every five minutes until 1.25 mg. had been given. After one of these treatments had been given, the patient received placebo every five minutes for 30 minutes.

Results

Schizophrenic patients. As shown in table 3, treatment with physostigmine reversed the increases in the activation scale ratings and the decreases in the inhibition scale ratings that had been produced by methylphenidate.

Manic patients. Similarly, the increase in the activation scale ratings that had been produced by methylphenidate (change score: $3.42 \pm .30$, $p < .005$) was reversed by treatment with physostigmine (change score: $-4.01 \pm .86$, $p < .0005$). This reversal did not occur when neostigmine or placebo was administered.

All patients. For all patients who were first given methylphenidate, then physostigmine, methylphenidate caused a significant increase in the activation scale ratings (change score: $2.51 \pm .79$, $p < .005$), an increase that was reversed following the administration of physostigmine (change score: $-4.01 \pm .86$, $p < .0005$). This reversal did not occur when neostigmine or placebo was administered.

EXPERIMENT C: ANTAGONISM BY METHYLPHENIDATE OF PHYSOSTIGMINE'S INHIBITING EFFECTS

Method

The subjects were seven schizophrenic and six manic patients. They were first given 1.0 mg. of methylscopolamine, then a variable number of doses of placebo at five-minute intervals, and finally physostigmine. Administration of physostigmine was repeated at five-minute intervals until a total of 2.5 mg. had been given or until the drug had produced a state of inhibition. Once this state appeared, the patients received, in succession and at five-minute intervals, two doses of placebo, 10 mg. of methylphenidate, and six more doses of placebo. Eight other patients received doses of 0.25 mg. of neostigmine instead of the 0.5 mg. of physostigmine.

TABLE 4
The Antagonism of the Effects of Physostigmine by Methylphenidate in Seven Schizophrenic Patients

Item	Stages of Experiment		
	Baseline and Placebo	Administration of Physostigmine	Administration of Methylphenidate
Inhibition scale	7.54±2.83	15.50±2.92*	9.73±1.74**
Activation scale	5.33±1.26	2.64±0.74***	3.71±0.56***
Cheerfulness	0.50±0.33	0.04±0.04	0.03±0.03
Friendliness	1.41±0.27	0.80±0.25***	0.83±0.22
Interaction	1.79±0.39	0.90±0.24***	1.46±0.24***
Talkativeness	1.63±0.38	0.90±0.24***	1.40±0.17***
Other			
Irritability	0.81±0.44	0.20±0.20	0.26±0.19
Depression	0.71±0.18	1.10±0.48	1.23±0.54
Psychosis	1.69±0.55	1.61±0.46	1.96±0.30
Emotional withdrawal	1.39±0.46	1.90±0.51***	1.23±0.46***
Conceptual disorganization	1.46±0.53	1.84±0.50	1.71±0.44
Unusual thought content	1.04±0.52	0.96±0.40	1.49±0.32
Blunted affect	1.79±0.49	2.19±0.51***	1.57±0.44

* The difference between this rating and that in the preceding column is significant, $p < .001$.
** The difference between this rating and that in the preceding column is significant, $p < .01$.
*** The difference between this rating and that in the preceding column is significant, $p < .05$.

Results

Schizophrenic patients. As shown in table 4, the increase in the inhibitory scale ratings produced by physostigmine was rapidly reversed by treatment with methylphenidate. Moreover, physostigmine completely prevented the increase over baseline in activation and partially prevented the increase in ratings for psychosis that are normally produced by methylphenidate (see tables 1 and 4).

Manic patients. The increase in the inhibition scale ratings produced by physostigmine (change score: 10.68 ± 1.87, $p < .0001$) was partially reversed by the administration of methylphenidate (change score: -4.75 ± 1.88, $p < .03$).

All patients. For the total group of patients, the increase in the inhibition scale ratings that had been produced by physostigmine (change score: 8.27 ± 1.29, $p < .0003$) was partially reversed by treatment with methylphenidate (change score: -4.89 ± 1.26, $p < .0015$). Conversely, treatment with physostigmine caused a decrease in activation scale ratings (change score: $-2.52 \pm .74$, $p. < .003$), which was partially reversed following the administration of methylphenidate (change score: $1.42 \pm .65$, $p < .03$). It is significant that the reversal of physostigmine's effects by methylphenidate occurred 30 to 120 seconds after the administration of methylphenidate. By contrast, the eight patients who received neostigmine, then methylphenidate, displayed no inhibition. Furthermore, the administration of neostigmine failed to inhibit the action of methylphenidate in significantly increasing the activation scale ratings or significantly decreasing the inhibitory scale ratings.

DISCUSSION

Our findings indicate that methylphenidate, an adrenergic stimulating agent, and physostigmine, a cholinomimetic agent, produce opposite effects when each is given alone and antagonistic effects when they are given sequentially. In our study, methylphenidate intensified manic symptoms in manic patients, increased the symptoms of psychosis in schizophrenic but not manic patients, and produced a marked increase in activation (noted especially in the items "talkativeness" and "interactions") in all patients. Physostigmine produced an inhibitory syndrome that was similar to the psychomotor retardation seen in endogenous depression. Patients slowed down, became lethargic, and claimed to have no thoughts in their heads at all. It is significant that physostigmine alone did not decrease psychotic thinking in schizophrenics. For both manic and schizophrenic patients, physostigmine's inhibitory effect was reversed by treatment with methylphenidate. Conversely, methylphenidate's activating effect was reversed by physostigmine. The physostigmine reversed the intensification of the schizophrenic patients' symptoms of psychosis that had been produced by methylphenidate. Physostigmine's reduction of mania was reversed by methylphenidate.

A number of methodological considerations deserve mention. The doses of neostigmine we used were lower than those of physostigmine because neostigmine has a peripheral potency that is two to three times greater than that of physostigmine (5). In our experiments, 0.25 mg. of neostigmine was slightly more potent than 0.50 mg. of physostigmine. Neostigmine did cause bradycardia, indicating that it exerted significant peripheral cholinomimetic effects in this dosage range in spite of the previous administration of methylscopolamine.

Neostigmine decreased the "unusual thoughts" ratings for the schizophrenic patients. This finding might have occurred by chance alone[1]; but it could just as readily reflect a placebo effect or a real effect. The significance of this finding is uncertain; consequently, the finding is reported without interpretation.

It is likely that the inhibition produced by physostigmine is not due to the soporific effects of the drug, because all patients remained oriented to time, place, and situation. It is possible, however, that the patients felt ill after receiving physostigmine. Although a number of the patients became nauseated and some vomited after receiving physostigmine, not all did and the inhibitory behavioral changes appeared at least five minutes earlier than nausea. Moreover, the vomiting often continued or began after the administration of methylphenidate, at a time when inhibition was decreasing. It is therefore possible, but unlikely, that the patients exhibited a decrease in their symptoms and energy because they felt physically ill.

It is important to note that our findings result from the acute (short-term) administration of various drugs. The results of chronic administration might be different. For example, diisopropylflurophosphonate, an irreversible cholinesterase inhibitor, caused an activation of schizophrenic symptoms in schizophrenic patients when administered chronically (13). Our findings do not indicate or rule out the possibility that the chronic administration of physostigmine might produce antipsychotic or psychotogenic effects.

In our study, we have used physostigmine as a pharmacological tool to understand the biology of mental illness. Except for its accepted use in the treatment of "central anticholinergic syndrome," we feel that physostigmine should be used only in a highly controlled setting, such as a metabolic unit, where the stringent evaluation of patients and the regulation of side effects can take place. Physostigmine has numerous contraindications. These include gastric and duodenal ulcers, diabetes, hyperthyroidism, gangrene, ulcerative colitis, intestinal obstruction, cardiac disease, respiratory diseases (including asthma, bronchitis, and emphysema), bladder obstruction, glaucoma, pregnancy, myotonia congenita, and myotonia atrophica. The drug should therefore be used with caution. Patients receiving it should be carefully

[1]At the .05 level of significance, one out of 20 statistical tests may by chance alone show a significant difference that does not actually exist. In this case, the measurement "unusual thoughts" was one of 27 taken on the schizophrenic patients and one of 63 taken on the combined patient group.

evaluated. However, its ability to rapidly alleviate manic symptoms and to induce a generalized inhibitory state without obtunding may suggest some potential as a rapidly acting antimanic agent.

It is likely that our findings in human subjects correspond to similar findings with animals (2). Our study would therefore demonstrate drug-drug behavioral antagonisms that have been demonstrated previously only with laboratory animals using such measurements as locomotion, various kinds of operant conditioning, and passive avoidance behaviors (2, 11).

The simplest explanation of the antagonistic effects of adrenergic and cholinergic agents would be that these effects correspond to a balance between functionally opposite neurological systems. One system uses norepinephrine (or dopamine) and the other uses acetylcholine as the transmitter substance. Undoubtedly, there are many parts of the CNS in which antagonisms occur between the noradrenergic and/or dopaminergic system and the cholinergic system. The behavior observed in our experiments probably represents the overall effect of changes in transmitter substances as they affect a number of these functions.

In addition to antagonism, there is evidence that if one system is stimulated, there may be a compensatory activation of the other, which could later become unmasked and cause a compensatory rebound effect. Fibiger, Lynch, and Cooper (19) have demonstrated that the increase in cholinergic activity that is caused by the administration of physostigmine leads first to a decrease in locomotion but subsequently to an increase in locomotion as the presumed adrenergic rebound mechanism begins to exert its effect. The effect becomes apparent as the cholinergic activation that had been induced by physostigmine decreases. At the enzymatic level, a similar phenomenon has been observed. Choline acetylase, the enzyme that regulates the rate at which acetylcholine is synthesized, is stimulated by the infusion of methamphetamine (20) and norepinephrine (21). Therefore, on a behavioral and biochemical level, there is considerable evidence for the interaction and mutual antagonism of the cholinergic and adrenergic systems.

Our own findings and those obtained in the human and animal studies cited above support the concept that a component of human behavior can be placed on a continuum between "psychic activation" and "psychic inhibition." A relative balance between cholinergic and adrenergic central activity may therefore determine the level of behavioral activation or inhibition at any given time, just as such a balance determines heart rate and pupillary size in the peripheral nervous system. This concept of balance can be extended to abnormal affective states such as mania and depression, which have previously been conceptualized as due, respectively, to an increase and a decrease in noradrenergic functioning. In the light of our findings and other work, mania may represent in part a relative adrenergic predominance and retarded depression may represent a relative cholinergic predominance (11–13, 22, 23).

A number of other factors suggest that affective illnesses may be due in part to a balance between adrenergic and cholinergic factors (24). We have shown elsewhere that patients with an affective component to their illness, including schizo-affective and manic patients, display an increase in depression and sadness after receiving physostigmine. Patients with schizophrenic illness who do not have an affective component to their illness show no alteration of affect after treatment with physostigmine (25). In manic patients, physostigmine produces a marked decrease in global mania ratings (12). It is relevant to note that reserpine, traditionally viewed as a drug that decreases adrenergic activity, causes inhibition in animals and depression in man; it also has antipsychotic properties and has been reported to have central cholinomimetic properties as well (26). Tricyclic antidepressants, which are generally thought to work by increasing the activity of the adrenergic system, have central anticholinergic properties, as well as adrenergic effects (26). Anticholinergic agents such as scopolamine have euphoriant properties (27). Furthermore, tricylic antidepressants have been known to precipitate manic episodes.

These findings are important to the understanding of the biochemical factors that may cause schizophrenia. The "dopamine hypothesis of schizophrenia" implicates central dopamine activity in the etiology of schizophrenia (14, 28). This hypothesis is based in part on the observation that all effective antipsychotic medications block dopamine receptors in the central nervous system and are structurally similar to the dopamine molecule. Amphetamine and methylphenidate also produce stereotyped behavior in animals and a paranoid psychosis in man that closely resembles paranoid schizophrenia. Both effects are blocked by antipsychotic medications and are thought to be dopaminergic in origin. In our studies, it is significant that methylphenidate activates psychotic symptoms and that this phenomenon is blocked by the administration of physostigmine. Thus, the capacity of stimulants to intensify the symptoms of psychosis may be moderated by a balance between adrenergic and cholinergic factors. In our study, however, psychotic symptoms themselves were moderated but not actually removed by treatment with physostigmine. This would seem to indicate that the activation or worsening of psychotic symptoms is under the control of both adrenergic and cholinergic factors, while the presence or absence of the primary psychotic process itself (including manifestations such as delusions, hallucinations, and autistic thinking) is determined by noncholinergic factors.

In conclusion, we have found that increasing the activity of the central cholinergic system by treatment with physostigmine reverses mania; increases depression in patients with an affective component to their illness; antagonizes methylphenidate-induced activation of the CNS and activation in schizophrenic patients of psychotic symptoms; and causes an anergic syndrome consisting of drained feelings, apathy, slowed thinking, and psychomotor retardation. Furthermore, physostigmine's inhibitory effects are antagonized by methylphenidate. For these reasons, we feel that it is reasonable to hypothesize the existence of a dimension in man that goes from

an "excited-activated-euphoric" state to an "inhibited-retarded-depressed" state, and that this dimension may have as part of its basis a balance between adrenergic and cholinergic factors. The data presented in this paper may serve to define the role of cholinergic and adrenergic factors in influencing the course of depression and mania, the activity levels of schizophrenics, and the changes in activity and mood that are found in normal subjects.

REFERENCES

1. Goodman LS, Gilman A (eds): The Pharmacological Basis of Therapeutics, 4th ed. Toronto, Collier-MacMillan, Canada, 1970, pp 399–613
2. Carlton PL: Cholinergic mechanisms in the control of behavior by the brain. Psychol Rev 70:16–39, 1963
3. Brodie BB, Spector S, Shore PA: Interaction of drugs with norepinephrine in the brain. Pharmacol Rev 11:548–564, 1959
4. Davis JM: Theories of the biological etiology of affective disorders. Int Rev Neurobiol 12:145–175, 1970
5. Stark P, Boyd ES: Effects of cholinergic drugs on hypothalamic self-stimulation in dogs. Am J Physiol 205:745–748, 1963
6. Domino EF, Olds ME: Cholinergic inhibition of self-stimulation behavior. J Pharmacol Exp Ther 164:202–211, 1968
7. Olds ME, Domino EF: Comparison of muscarinic and nicotinic cholinergic agonists on self-stimulation behavior. J Pharmacol Exp Ther 166:189–204, 1969
8. Pfeiffer CC, Jenney EH: The inhibition of conditioned response and the counteraction of schizophrenia by muscarinic stimulation of the brain. Ann NY Acad Sci 66:753–764, 1957
9. Mennear JH: Interactions between central cholinergic agents and amphetamine in mice. Psychopharmacologia 7:107–113, 1965
10. Pradham SN, Dutta SN: Central cholinergic mechanisms and behavior. Int Rev Neurobiol 14:173–231, 1971
11. Janowsky DS, El-Yousef MK, Davis JM, et al: Cholinergic antagonism of methylphenidate-induced stereotyped behavior. Psychopharmacologia 27:295–303, 1972
12. Janowsky DS, El-Yousef MK, Davis JM, et al: Parasympathetic suppression of manic symptoms by physostigmine. Arch Gen Psychiatry 28:542–547, 1973
13. Rowntree DW, Nevin S, Wilson A: The effects of diisopropylfluorophosphonate in schizophrenia and manic depressive psychosis. J Neurol Neurosurg Psychiatry 13:47–62, 1950
14. Janowsky DS, El-Yousef MK, Davis JM, et al: Provocation of schizophrenic symptoms by intravenous administration of methylphenidate. Arch Gen Psychiatry 28:185–190, 1973
15. Scheel-Kruger J: Comparative studies of various amphetamine analogues demonstrating different interactions with the metabolism of catecholamines in brain. Eur J Pharmacol 14:47–49, 1971
16. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968
17. Beigel A, Murphy DL: Assessing clinical characteristics of the manic state. Am J Psychiatry 128:688–694, 1971
18. Bunney WE, Hamburg DA: Methods for reliable longitudinal observations of behavior. Arch Gen Psychiatry 9:114–128, 1963
19. Fibiger HD, Lynch GS, Cooper HP: A biphasic action of central cholinergic stimulation on behavioral arousal in the rat. Psychopharmacologia 20:366–382, 1971
20. Mandell AJ, Knapp S: The effects of chronic administration of some cholinergic and adrenergic drugs on the activity of choline acetyltransferase in the optic lobe of the chick brain. Neuropharmacology 10:513–516, 1971
21. Gershon S, Angrist B: Effects of alterations of cholinergic function on behavior, in Psychopathology and Psychopharmacology. Edited by Cole JO, Freedman AM, Friedhoff AJ. Baltimore, Johns Hopkins University Press, 1972, pp 15–36
22. Bowers MB, Goodman E, Sim VM: Some behavioral changes in man following anticholinesterase administration. J Nerv Ment Dis 138:383–389, 1964
23. Gershon S, Shaw FH: Psychiatric sequelae of chronic exposure to organophosphorous insecticides. Lancet 1:1371–1374, 1961
24. Janowsky DS, El-Yousef MK, Davis JM, et al: A cholinergic-adrenergic hypothesis of mania and depression. Lancet 2:632–635, 1972
25. Janowsky DS, El-Yousef MK, Davis JM: Acetylcholine and depression. Read at the annual meeting of the American Psychosomatic Association, Denver, Colo, April 6–8, 1973
26. Sulser F, Bickel MH, Brodie BB: The action of desmethylimipramine in counteracting sedation and cholinergic effects of reserpine-like drugs. J Pharmacol Exp Ther 144:321–330, 1964
27. Safer DJ, Allen RP: The central effects of scopolamine in man. Biol Psychiatry 3:437–455, 1971
28. Horn AS, Snyder SH: Chlorpromazine and dopamine: conformational similarities that correlate with the antischizophrenic activity of phenothiazine drugs. Proc Natl Acad Sci USA 68:2325–2328, 1971

EDITORIAL

Hereditary Transmission of Psychiatric Illness

THE FAMILIAL NATURE of most psychiatric disorders is generally recognized. The relative importance of heredity in such familial clustering, however, is still subject to controversy. Except for certain infrequent forms of mental deficiency, the familial distribution of psychiatric disorders has heretofore not been thought to fit simple Mendelian patterns. Generally, attempts to assess heredity in the transmission of most psychiatric conditions have been based upon studies of twins or adoptees.

Significantly increased concordance rates in monozygotic twins compared with dizygotic twins of the same sex, coupled with similar concordance rates in dizygotic twins and ordinary siblings of the same sex, have been taken as support for hereditary transmission. Similarly, increased prevalence rates in individuals separated early in life from biological parents with the same illness and raised by adoptive parents, compared with adopted controls whose biological parents were free of the illness, have been viewed as supporting hereditary transmission.

Such studies are based on assumptions that the environments of comparison groups are similar: that the environments of monozygotic twins, dizygotic twins, and ordinary siblings do not differ systematically; that the adoptive environments of compared children are the same; and that nonrandom adoption is infrequent. Such assumptions are obviously not free from challenge.

The "environment" includes an infinite number of potential etiologic factors. No two environments are totally alike. Until possibly relevant, specific environmental factors are identified, however, hypotheses concerning environment-heredity interaction cannot be tested critically. Reports consistently linking a particular environmental factor to a particular psychiatric illness are few. As yet, twin or adoptee studies explicitly controlling for specific environmental factors have been limited. While evidence for genetic transmission, based upon repeated studies of twins and adoptees exposed to environments that appear to be grossly similar, has been impressive for both schizophrenia and affective disorders, important questions remain unanswered, and some skeptics remain unconvinced.

If specific biological mechanisms underlying psychiatric illnesses were known and could serve as markers, studies of twins and adoptees would probably be more convincing. Lacking these, however, linkage studies may offer the most convincing evidence for hereditary transmission. Linkage refers to evidence that two or more traits are controlled by genes located close to one another on the same chromosome. X linkage refers to evidence that a given trait is transmitted by one or more genes located on the X chromosome. Because of the special nature of the sex chromosomes, X linkage usually provides the best opportunity to study linkage.

As shown initially by Winokur and his associates (1), and reported elsewhere in this issue of the *Journal* by Fieve and associates (2), evidence is accumulating that bipolar affective illness (manic-depressive disease) may be linked to both red-green color blindness and the Xg blood group, each the manifestation of genes on the X chromo-

In this section, the Editor samples varied opinions on topical problems. The opinions expressed herein are not necessarily those of the Editor, nor can they in any way be construed as marking the official policy of the Journal.

some. If further reports confirm these findings, hereditary transmission of at least some cases of affective illness will be on a firm basis.

Of additional interest is the observation noted by Fieve and associates (2) and by others (e.g., at a symposium on hereditary transmission of psychiatric illnesses held at the American Psychological Association meeting in New York City, March 1–2, 1973) that X linkage is not found in all pedigrees. This suggests that bipolar affective illness may be the result of at least two different phenotypes or that some cases may not be genetically transmitted. If these observations are also confirmed, clinical and therapeutic differences may be found associated with different modes of transmission, and new research areas will open.

Much additional work remains to be done, but convincing evidence for hereditary transmission of at least some forms of schizophrenia and affective illness appears to be mounting. Rather than discouraging investigators studying possible environmental transmission, however, findings concerning the role of heredity may lead to more refined and precise studies. Significant environmental etiologic factors may become evident only when research is carried out that suitably controls for hereditary influences.

REFERENCES

1. Winokur G, Clayton PJ, Reich T: Manic-Depressive Illness. St Louis, CV Mosby Co, 1969
2. Fieve RR, Mendlewicz J, Fleiss JL: Manic-depressive illness: linkage with the Xg blood group. Am J Psychiatry 130:1355–1359, 1973

SAMUEL B. GUZE, M.D.

Dr. Guze is Vice Chancellor for Medical Affairs and Professor of Psychiatry, Washington University School of Medicine, St. Louis, Mo.

BRIEF COMMUNICATIONS

Phases of Psychopathology After Assassination

BY JOSEPH C. FINNEY, LL.B., M.D., PH.D., DONALD E. SKEETERS, M.S.ED., J.D., C. DWIGHT AUVENSHINE, PH.D., AND DAVID F. SMITH, M.B.A.

An Arabic man who assassinated a prominent American politician was tested with the Minnesota Multiphasic Personality Inventory six weeks and five months after the crime. Analysis of both tests by a psychiatric diagnostic computer program revealed a schizo-affective psychosis with paranoid features. The authors recommend the computer method of diagnosis for medicolegal cases in which public opinion has been aroused and the specialist's objectivity may be impaired.

THE SUBJECT, a young man of Arabic origin, assassinated a prominent American political figure in 1968. He was examined and tested by psychologists six weeks later and again five months after the crime. At the trial a plea of diminished responsibility, but no plea of insanity, was made. Expert witnesses (psychiatrists and psychologists) all agreed that the defendant was paranoid but disagreed about the presence of psychosis or schizophrenia. The jury convicted him.

Later, the Minnesota Multiphasic Personality Inventory (MMPI) scores for both tests were analyzed by computer, using a standard method (1, 2). The system scores more than 150 scales and makes corrections to take into account any attempt to exaggerate or deny psychopathology. Factor scores are computed on both corrected and uncorrected scale scores.

The subject's mood, attitude, and view of himself shifted markedly between the two examinations. In the earlier test he said that he had not led the right kind of life, that his future looked hopeless, and that most of the time he would rather be dead. He gave several unusual answers; for example, he said that evil spirits sometimes took possession of him, that his soul sometimes left his body, that he heard strange things when he was with people, and that he had had strange thoughts and experiences. He appeared pessimistic in spite of some efforts at denial of his problems. The computer judged him to be chronically as well as somewhat acutely troubled, and in assessing his mental health prognosis it commented, "The long-term outlook for him is not good."

By the time of the second examination the subject seemed to have pulled himself together and to have reached a better homeostasis. His scores on the L, F, and K scales shifted from 65/78/47 (Minnesota Norms) to 45/64/48 respectively.[1] He gave fewer strange answers, although he still stated that evil spirits sometimes took possession of him. The computer noted, "He seems about as free from distress as the average person." The whole picture looked so much better the second time that the computer, while still diagnosing psychosis, altered its long-range prognosis to a favorable one.

Certain personality factors showed a shift between the two testings. From the results of the early test the computer described the subject as discouraged, hostile, and very bitter, headstrong and rather demanding, alienated

At the time this work was done the authors were all with the University of Kentucky College of Education, Lexington, Ky. 40506, where Dr. Finney is Professor of Educational Psychology and Counseling, Mr. Skeeters and Mr. Smith were Research Assistants in Educational Psychology and Counseling, and Dr. Auvenshine is Associate Professor of Educational Psychology and Counseling. Mr. Skeeters is now in the private practice of law in Elizabethtown, Ky., and Mr. Smith is Instructor in Computer Science and Management, Kentucky State College, Frankfort, Ky.

Test responses were provided by psychologists O. Roderick Richardson, Martin M. Schorr, and George DeVos and by the Los Angeles County Clerk's Office.

The *Journal* wishes to assure its readers that publication of this paper does not constitute a breach of ethics or of confidentiality, since the material discussed is part of a public record and is therefore in the public domain. In addition, approval for publication was obtained from the subject's lawyer and from attorneys for the American Psychiatric Association.

[1] Scales L, F, and K are measures of the attitude with which the patient took the test. Average normal values are 50 for all three scales. Extreme elevation of F (especially if L and K are low) may show overfrankness, malingering, or a helpless attitude; F scores are also elevated by psychosis and by foreign language or culture. Elevation of the L score, as seen on the first test, is a naïve denial of minor flaws of character and may show high use of the hysterical defenses of repression and denial.

from society and unwilling to conform to its customs, and troubled by guilt but denying it. These qualities faded on the later test, on which the computer described the subject as narcissistic, seeking affection, and "willing to conform to the customs and expectations of society."

Some clinicians also found strong hysterical features in the defendant. Our computer uses as its measure of hysterical defenses (repression and dissociation) the "hysterical index" calculated as the average of nine scale scores. It does not vary with general anxiety or with social desirability set. Persons with scores of 55 or greater are designated as showing hysterical features. The defendant showed such features in the first testing and the hysterical features were designated. On the later testing the evidence of hysterical defenses was found to have disappeared; the hysterical index was 48. Perhaps the explanation is that hysterical defenses drop out of use as hypomania arises.

Despite these shifts in the test product, the computer showed remarkable constancy in its diagnostic judgment, finding a combination of schizophrenia and affective psychosis. The schizophrenic and paranoid elements remained constant, while the manic-depressive component shifted from a depressed to a manic phase. From the results of the first test the subject was diagnosed, according to the official APA nomenclature (3), as suffering from "schizophrenia, schizo-affective type, depressed" (category 295.74), with paranoid features. On the second test the computer's diagnosis was "schizophrenia, paranoid type" (category 295.3); it also suggested that another possible classification was "schizophrenia, schizo-affective type, excited" (category 295.73), with paranoid and manic features. Both times the list of other diagnoses, named by the computer as alternative possibilities, consisted of paranoia or paranoid psychosis, paranoid personality, and organic brain syndrome.

Other important features remained constant through both testings, as judged by the computer. The subject's most prominent defense mechanism was projection of hostility. Denial was also prominent. On both occasions the subject was judged to be ethical to an average degree and not sociopathic or irresponsible. He was judged as average or normal in his ability to work. An asset toward success in work was his carefulness and accuracy, but he was found lacking in other elements that would correlate with success in college. He was found to be psychotic both times, and to an equal degree.

DISCUSSION

This single case report is presented to stimulate investigation into the problems of constancy and change in psychopathology, the prediction of violence at certain measurable phases of pathology, and the usefulness of computers in psychiatric diagnosis and psychological assessment. Repeated administration of a standardized personality test at regular intervals, with computer-standardized interpretation, can be helpful in such investigations.

In medicolegal cases where the emotions of the public have been aroused, it is difficult for the expert witness to be sure of his objectivity; it may be well to reinforce the psychiatrist's objectivity with a computer, which is impervious to such influences.

REFERENCES

1. Finney JC: Programmed interpretation of MMPI and CPI. Arch Gen Psychiatry 15:75–81, 1966
2. Finney JC: Methodological problems in the programmed composition of psychological test reports. Behav Sci 12:142–152, 1967
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968

Prevention of Alcohol Withdrawal Seizures: The Roles of Diphenylhydantoin and Chlordiazepoxide

BY EMIL ROTHSTEIN, M.D.

Two hundred patients with histories of chronic alcoholism and recent bouts of heavy and uncontrolled drinking were treated for alcohol withdrawal symptoms through the use of chlordiazepoxide and thiamine. One hundred of these patients, chosen at random, also received diphenylhydantoin. No withdrawal seizures occurred in either group, nor were any other differences observed. Patients with a history of previous withdrawal seizures were included in both treatment groups. These observations suggest that when adequate doses of chlordiazepoxide and thiamine are used during alcohol withdrawal, no additional anticonvulsant drug is needed to prevent seizures.

IN THIS REPORT we will attempt to assess the role of diphenylhydantoin (Dilantin), when used in conjunction with chlordiazepoxide (Librium) and thiamine hydrochloride, in the prevention of convulsive seizures during alcohol withdrawal. When a person has been drinking heavily for a considerable period of time the level of ethanol in his blood becomes elevated; its sudden lowering following alcohol withdrawal is often followed by convulsive seizures. The exact height and duration of the elevated ethanol level needed to induce seizures is uncertain, but seizures occur frequently in alcoholics who have been drinking heavily for many days or weeks. Seizures can also be induced in mice, rats, dogs, monkeys, and apes by giving these animals large quantities of alcohol and then withdrawing it. There are, of course, other symptoms of alcohol withdrawal as well, but this paper will focus specifically on convulsive seizures.

SUBJECTS

Our study was carried out with 200 of the 234 patients who were admitted over an 18-month period to a four-bed detoxification section of an alcoholism treatment and rehabilitation program. To be eligible for admission to the detoxification section the applicant was required to have a history of chronic alcoholism and to have been drinking heavily (480 ml. of hard liquor or the equivalent in other alcoholic beverages) every day for at least five days immediately preceding his admission. In almost all cases, however, the amount and duration of drinking appreciably exceeded these minimum criteria. Patients were also required to give their written, informed consent to participation in the treatment program.

The other 34 patients in the detoxification section during the 18-month period under study were excluded from our treatment program for the following reasons: previous long-term diphenylhydantoin therapy for convulsive disorders (other than withdrawal seizures) (N = 10); seizures during the two weeks just before admission (N = 9); improper admissions (drinking for a period of less than five days) (N = 9); refusal or inability of the patient to give his consent to participation (N = 4); and unwillingness of the patient's admitting officer to prescribe chlordiazepoxide in the recommended dosage (N = 2).

METHOD

The 200 eligible subjects were randomly assigned to either a diphenylhydantoin treatment group or a control group, using the following procedure: At the start of the study we obtained a random-number list of 200 numbers (balanced after each 20 to assure equal odd and even numbers). Upon admission to the detoxification section each new patient who was eligible for participation in the treatment program was assigned the next available number in the random-number list; cases with odd numbers received diphenylhydantoin and cases with even numbers served as controls.

The medication for the control group consisted of 100 mg. of thiamine hydrochloride administered orally every day for five days and 50–100 mg. of chlordiazepoxide administered orally or intramuscularly every few hours for the first 24 hours—as needed to maintain the patient in a somnolent state. After this period the medication was given when it was needed for relief of anxiety, tremors, insomnia, etc. In addition to these drugs the diphenylhydantoin treatment group received 400 mg. of diphenylhydantoin administered orally in doses of 200 mg. twice daily for five days. The average dose of chlordiazepoxide during the first 24 hours was 360 mg.; this amount was essentially the same for both groups.

The patients were allowed to drink fluids freely; there were no particular diet restrictions. Continuous nursing care was available, and somatic and psychological abnormalities were carefully recorded. No other medications were used on a routine basis, although antacids and antibiotics were occasionally administered.

Dr. Rothstein is Chief, Alcoholism Unit, Veterans Administration Hospital, Brockton, Mass. 02401.

RESULTS

No seizures were observed in any of the 200 subjects. Forty subjects had a history of seizures during previous episodes of alcohol withdrawal; 22 of these received diphenylhydantoin in this study and 18 of them served as controls. A mild form of delirium tremens (manifested by a combination of hallucinations, disorientation, and tremors [1]) developed after admission in nine patients, five of whom were receiving diphenylhydantoin. There were no deaths or serious physical outcomes despite scattered cases of diabetes, cirrhosis, and cardiac disease that were already present at the time of admission.

DISCUSSION

The cause of alcohol withdrawal seizures is uncertain, but probably they can be explained as follows: In response to the depressive effect of a sustained elevation of blood ethanol, neurons increase their chemical and electrical activity. The pharmacological effect of the ethanol subsides rapidly, but the neuronal activity remains high for 24 to 96 hours. During this period (especially the first 48 hours) appropriate stimuli may lead to a diffuse discharge producing a grand mal seizure.

This hypothesis is supported by the finding that during this period of ethanol withdrawal an electroencephalogram may show a heightened response to photic stimuli. Victor and Brausch (2) tested patients during ethanol withdrawal by exposing them to fast-frequency photic stimulation. They observed a close temporal relationship between abnormal photic responses (photomyoclonus, convulsions, paroxysmal discharges on the EEG) and spontaneous seizures. The peak frequency of seizures occurred between 31 and 48 hours after the cessation of drinking. The period of photosensitivity is usually limited to five days after ethanol withdrawal.

The prevention of severe withdrawal symptoms is one of the two major functions of an alcohol detoxification program (the other is to attempt to enlist the patient in a long-term program of rehabilitation). On the basis of theoretical considerations as well as empirical findings, a gradual rather than abrupt drop in the depressant effect of the alcohol would seem to be desirable. Alcohol is not, however, the best substance to use for purposes of detoxification. Fortunately, chlordiazepoxide has been shown to be very effective for this purpose. In a controlled cooperative study on the use of chlordiazepoxide in a number of VA hospitals (3), this drug proved more effective in preventing seizures and delirium tremens than did chlorpromazine, hydroxyzine, placebo, or thiamine. Only one percent of the patients receiving chlordiazepoxide had seizures.

No report could be found of a controlled study assessing the value of diphenylhydantoin in preventing alcohol withdrawal seizures. However, there are reasons for doubting its efficacy in such treatment. Unless 1.0 to 1.2 grams of diphenylhydantoin is given as a rapid loading dose, it takes from five to 15 days to achieve a therapeutic level of the drug (4). Essig and Carter (5) found diphenylhydantoin to be ineffective in preventing barbiturate withdrawal seizures in dogs. There is reason to believe that the seizures provoked by alcohol and barbiturate withdrawal are similar in origin, and the two drugs are cross-dependent as far as withdrawal symptoms are concerned (6).

Aside from the possible inefficacy of diphenylhydantoin in preventing withdrawal seizures, there is the question of whether the drug is needed. Chlordiazepoxide has been shown to be prophylactic against seizures (7, 8). In the cooperative VA study referred to above—which is perhaps the most valuable report on this subject—seizures were observed in one percent of the subjects receiving chlordiazepoxide, 12 percent receiving chlorpromazine, eight percent receiving hydroxyzine, seven percent receiving placebo, and seven percent receiving thiamine (each group had about 100 subjects) (3). One difference between these patients and ours was that the minimum period of continuous drinking required for admission to the VA cooperative study was two weeks, whereas for our study it was five days. However, the large majority of our patients had also been drinking for two weeks or longer.

The role of thiamine is impossible to assess. In the VA study (3) thiamine alone was no more effective than placebo. This does not, however, rule out an anticonvulsive effect when it is used in combination with other medications. In any case, the results of our study indicate that chlordiazepoxide and thiamine, when given in adequate dosages, are so effective in the prevention of alcohol withdrawal seizures that additional anticonvulsive medication is not needed.

REFERENCES

1. Wolfe SM, Victor M: The physiological basis of the alcohol withdrawal syndrome, in Recent Advances in Studies of Alcoholism. Edited by Mello NK, Mendelson JH. Washington, DC, National Institute of Mental Health, 1971, pp 188–199
2. Victor M, Brausch J: The role of abstinence in the genesis of alcoholic epilepsy. Epilepsia 8:1–20, 1967
3. Kaim SC, Klett CJ, Rothfeld B: Treatment of the acute alcohol withdrawal state: a comparison of four drugs. Am J Psychiatry 125:1640–1646, 1969
4. Easton JD: Diphenylhydantoin and epilepsy management. Ann Intern Med 77:421–423, 1972
5. Essig CF, Carter WW: Failure of diphenylhydantoin in preventing barbiturate withdrawal convulsions in the dog. Neurology 12:481–484, 1962
6. Essig CF, Jones BE, Lam RC: The effect of pentobarbital on alcohol withdrawal in dogs. Arch Neurol 20:554–558, 1969
7. Kaim SC, Rosenstein IN: Experience with chlordiazepoxide in the management of epilepsy. Journal of Neuropsychiatry 3:12–17, 1961
8. Kaim SC, Rosenstein IN: Anticonvulsant properties of a new psychotherapeutic drug. Dis Nerv Syst 21(March Suppl):46–48, 1960

Self-Destructive and Suicidal Behaviors in a Neuropsychiatric Inpatient Facility

BY JUDITH JANARO FABIAN, PH.D., MICHAEL P. MALONEY, PH.D., AND MICHAEL P. WARD, PH.D.

This study of self-destructive behavior in a psychiatric hospital suggests that persons making the most serious attempts are likely to be suffering from a depressive reaction and to make their attempt during the day (particularly in the early afternoon); they are not likely to repeat the attempt during their hospitalization. In contrast, persons making less serious attempts are likely to have been diagnosed as suffering from adjustment reaction or schizophrenic reaction and to make their attempt during the evening hours; they tend to make recurrent superficial attempts during one period of hospitalization.

IN RECENT YEARS there has been an upsurge of interest in the study and treatment of suicide. The finality of suicide places severe constraints on its study and treatment and makes suicide unique as a psychiatric problem. Fractured egos can be "mended," behavioral repertoires can be altered by applying one of the various therapeutic "remedial" techniques in the psychiatric armamentarium, and there is always the luxury of trying another technique if the first proves unsuccessful. However, the very nature of suicide dictates that the approach be preventive rather than remedial, at least in the initial phases of the problem.

The essential ingredient of any preventive approach is the ability to identify and delineate the high-risk population. Because of the severe consequences involved, all suicide threats and gestures have to be taken seriously; but from a practical point of view, some are more serious than others, and this distinction has to be made. Knowledge of patient and environmental factors must be obtained, at least in a probabilistic sense, to aid in the crucial evaluative and judgmental process. Some progress has already been made in this identification process for the general population (e.g., women make more attempts than men, but men are more successful; there are age and seasonal variations) (1–4), but the surface has only been scratched and much is still unknown.

One of the unknowns, surprisingly, is an analysis of suicidal and self-destructive behavior in a psychiatric hospital. Many persons in such institutions are there (voluntarily or involuntarily) because they are considered to be a danger to themselves. Many of these people have already defined themselves as part of the high-risk population by their very verbalizations and actions. Yet despite the fact that psychiatric hospitals abound with self-destructive behavior on a variety of levels of potential destructiveness, there is a paucity of data related to the range of such behavior occurring within the confines of the psychiatric setting.

Studies of suicide among hospital patients tend to be retrospective reviews of patients who succeeded in committing suicide while they were on hospital rolls—i.e., on leave, trial visit, pass, etc. (5)—or of those who died by suicide while they were inpatients or in some specified time interval following discharge (6). These patients are then compared with randomly selected controls or with those deemed to be high-risk patients. In these cases the data are combined in such a way that subjects who were not actually in the hospital at the time of the attempt are included. Consequently, conclusions that are drawn with regard to "in-hospital" variables are contaminated by external environmental factors that may be operative for some of the patients.

It appears that a more thorough analysis of the self-destructive behavior of inpatients is needed. With this knowledge the hospital staff can be alerted to crucial variables and take appropriate precautionary measures. Such information will also be of value in helping to understand the phenomenon of self-imposed death.

In this paper we are making an attempt to describe the entire range of self-destructive behavior within a psychiatric setting and to identify variables that can aid in the crucial discrimination between behaviors that are simply attention-provoking in nature and in motivation and those of a more determined suicidal purpose.

METHOD

Data for this study were obtained from special incident reports ("Report of Incident") filed between January 1968 and November 1971 in the psychiatric hospital of the Los Angeles County-University of Southern California Medical Center. Such reports are filed immediately by the charge nurse when any incident involving possible injury to a patient occurs.

For our purposes all reports during this interval involving self-destructive or suicidal behavior were selected for evaluation. These reports, 230 in all, were then classified into one of three categories (labeled I, II, and III) on the basis of severity of the attempt. Classification criteria for the categories were strictly behavioral; no attempt

At the time this study was done Dr. Fabian was Assistant Clinical Professor of Psychiatry (Psychology), University of Southern California School of Medicine, Los Angeles, Calif., where Dr. Maloney is Assistant Professor of Psychiatry (Psychology) and Dr. Ward is Staff Psychologist. Dr. Fabian is now Psychologist, Tamalpais Union High School District. Her address is 99 Lyford Dr., #41, Tiburon, Calif. 94920.

was made to assess motivation per se. Appendix 1 presents the specific criteria for categories I, II, and III. Category I, which includes minor or superficial attempts, included 142 cases; category II, more serious attempts, had 75 cases; and category III, potentially or actually lethal attempts, had 13 cases.

The categories were further analyzed for age, sex, type of incident, number of repeat attempts, time of day, and psychiatric diagnosis.

RESULTS AND DISCUSSION

A variable of potential interest was the time of day during which the incidents occurred. For this analysis, the day was broken into six four-hour blocks. A 3 x 6 (categories by time of day) chi-square contingency table analysis ($\chi^2=20.23$, df=10; $p < .05$) revealed significant differences in the time periods in which the incidents occurred for the three groups. For all three categories, the majority of incidents occurred between noon and midnight (80 percent, 76 percent, and 60 percent for categories I, II, and III, respectively). For category III, the remaining 40 percent of the incidents occurred during the early morning hours. However, the variability within the time segments was of special interest. Most attempts in both categories I and II occurred between 8 p.m. and 11:45 p.m., the time when patients prepare for and go to sleep, when they are inactive, and when the preoccupations of the day are no longer available. Surprisingly, in category III no attempt occurred during this time. Rather, 54 percent of the attempts in this category occurred between noon and 3:45 p.m., a period in which more staff is on duty than at other times and, although naps are permitted during this interval, there is a multitude of activities as well as therapeutic interventions (occupational, recreational, and group therapy). In fact, 77 percent of all potentially serious attempts occurred between 8 a.m. and 3:45 p.m. This suggests that day-shift personnel should be aware that less frequent but more serious attempts will be made during the day, while night-shift personnel will have to deal with more frequent but less serious episodes.

Two other variables examined in this study are age and sex. In general, the results are consistent with past research. A series of t tests comparing the ages of persons in each category indicates that patients in category I (mean chronological age, 19.6; S.D., 8.7 years) were significantly younger than patients in category II (mean age, 22.3; S.D., 9.2 years; $p < .05$) and patients in category III (mean age, 32.4; S.D., 9.7 years; $p < .001$), and that patients in category II were significantly younger than patients in category III ($p < .001$). This agrees with previous findings indicating that while attempts are more common in persons under 30, actual suicides are more common in persons over 30 and that there is an increase in rate with age (1).

With respect to sex, a 2 x 3 (sex by category) contingency table chi-square analysis revealed significant differences ($\chi^2 = 8.13$, df = 2; $p < .02$) in the percentage of men and women in the three categories. While women comprised approximately 60 percent (N= 165) of all cases, there is an interesting breakdown by category. In categories I and II, women accounted for 72 percent and 77 percent of the incidents respectively, while in category III they accounted for only 30 percent. In short, the women predominated in minor or superficial attempts but were underrepresented in the category characterized by potentially or actually lethal attempts. Past research has also suggested that suicide is a masculine phenomenon but that suicide attempts are predominantly a feminine phenomenon (1).

In terms of the type of incidents for the three categories listed in appendix 1, the majority of the persons in category I (63 percent) performed superficial acts involving laceration; this was followed by incidents of ingestion (27 percent). None of the incidents in this group involved attempted hanging or suffocation. The predominant type of incident for patients in category II was also laceration (53 percent), but it was of a more serious nature than in category I. Approximately 15 percent of the patients in category II were involved in incidents of ingestion and 12 percent in incidents of hanging. In category III, 23 percent of the incidents involved laceration, 23 percent ingestion, 15 percent head-banging, 30 percent hanging, and approximately seven percent suffocation.

The patients in category III used methods that were less likely to be reversible—e.g., hanging, suffocation, jumping off a bridge or its equivalent. Although both hanging and suffocation appear in category II, the attempt resulted in no physical consequences that required medical treatment. The self-administered abrasions included in category III involved vital organs rather than the extremities, as in categories I and II. In category III ingestion referred to substances known to be caustic or toxic, while in categories I and II it referred to small quantities of pills or other items. Potential reversibility seemed to be critical to the mode of attempt. Of course, it must be noted that since our classificatory scheme is based on behavioral criteria, some modes of attempt by definition will appear in some categories and not others; i.e., suffocation is applicable only to categories II and III because of its implicit lethality.

Another important variable in understanding the phenomenon of self-destructive behavior is the number of repeat attempts. In category I, 15 percent of the patients were involved in two or more attempts; in category II the figure dropped to eight percent; there were no repeat attempts in category III. (It should be noted that in category III only three patients made fatal attempts, thus repetition was possible for the remainder of this group.) There was relatively little overlap between patients in severity of attempts; in fact, in only one case did an individual make attempts that appeared in all three categories of lethality.

A somewhat paradoxical implication of these findings is that those who make the most attempts at suicide are least likely to be successful in the sense that they tend to use more superficial methods. Of course, there is an obvious selection factor for those who make more lethal at-

tempts and thereby preclude the possibility of repetition. The other implication of these findings is that those who make superficial attempts are more likely to make other superficial attempts rather than change to an attempt of greater severity or lethality.

A further breakdown of the data concerns psychiatric diagnosis. In category I, 21 percent of the patients were diagnosed as having adjustment reaction of adolescence, 18 percent as having schizophrenic reaction, and nine percent as having depressive reaction; the figures for category II were 19 percent, 35 percent, and 17 percent, respectively. In contrast, in category III only seven percent of the patients were diagnosed as having adjustment reaction of adolescence and 15 percent as having schizophrenic reaction, but 46 percent were diagnosed as having depressive reaction or severe depression. Combined data from other studies of suicidal patients indicate that the major diagnoses were schizophrenic reaction, affective reaction (depressive psychoses), and organic reaction (7). Our data suggest that consideration of the lethality or severity of the attempt adds useful discriminating information when the relationship between diagnosis and suicide is examined.

One of the difficulties encountered in a study of this nature is in discriminating between self-destructive incidents that are not motivated by fatal intention and true suicide attempts. Because of obvious methodological difficulties, we have not attempted to make this distinction. However, it is possible that reported statistics also fail to discriminate in this labeling process. Is it valid to consider an attempt to be of a suicidal nature on the basis of individual reports of intention, therapist opinion, or on the basis of behavior? Each of these is subject to question.

Another problem may lie in the accuracy of the incident reports that provided the basic data for this study. They were filled out by a variety of nursing personnel; diagnoses referred to may have been initial diagnoses on admission rather than final diagnoses; descriptions of incidents may have been impressionistic and based on patient report rather than on observation at times. However, the criteria for our category system were based primarily on observable components with the exception of the ingestion items, where the effects were internal and could not be observed.

REFERENCES

1. Dublin LI: Suicide: A Social and Statistical Study. New York, Ronald Press, 1963
2. Stengel E: Suicide and Attempted Suicide. Baltimore, Penguin Books, 1969
3. Massey JT (ed): Suicide in the United States, 1950–1964. Public Health Service Publication 1000. Washington, DC, US Government Printing Office, 1967
4. Shneidman ES, Farberow NL: The Cry for Help. New York, McGraw-Hill Book Co, 1961
5. Farberow NL, Shneidman ES, Neuringer C: Case history and hospitalization factors in suicide of neuropsychiatric hospital patients. J Nerv Ment Dis 140:32–44, 1966
6. Wilson GC Jr: Suicide in psychiatric patients who have received hospital treatment. Am J Psychiatry 125:752–757, 1968
7. Watkins C, Gilbert JE, Bass W: The persistent suicide patient. Am J Psychiatry 125:1590–1593, 1969

APPENDIX 1

Categories of Self-Destructive Behavior [1]

CATEGORY I

Abrasions: Any cut or laceration to the extremities that did not require suturing or butterfly bandage
Fire: Lighting material on the extremities of the body or singeing the hair
Head-banging: Hitting the head; no evidence of bruises, contusions, or lacerations
Ingestion:[2] Swallowing one or more thumbtacks; swallowing a small section of a thermometer or beads; biting a thermometer (no evidence of ingestion); ingesting nontoxic fluids such as shampoo or pills
Scalding: Scalding body parts other than the head

CATEGORY II

Abrasions: Slashing of the wrist that did not require sutures or the equivalent (e.g., pressure bandage) or similar slashing of an extremity; a cut or laceration of the torso (head, neck, or body) that did not require suturing or butterfly bandage
Fire: Lighting clothing or equivalent in the torso or head area
Head-banging: Hitting the head that resulted in bruises or lacerations requiring medical treatment
Ingestion:[2] Swallowing an open safety pin or part of a thermometer one inch long or longer; ingesting toxic fluids or pills
Miscellaneous: Mutilation of sex organs; injury requiring transfer to a medical unit for treatment
Scalding: Scalding the head
Suffocation: Use of an instrument wrapped around the neck or otherwise to prevent breathing that did not require medical treatment for physical consequences

CATEGORY III

Abrasions: Any wound to the head, neck, or torso that required suturing or its equivalent
Fire: Lighting clothing or its equivalent and using an additional activator
Ingestion: Ingesting caustic fluids or large amounts (more than six ounces) of toxic fluids or pills
Jumping: Jumping from a significant height (more than 20 feet or two stories or more) onto a hard surface
Suffocation: Use of an instrument wrapped around the neck or otherwise to prevent breathing that did require medical treatment for physical consequences

[1] Some types of injury may appear in all three categories; others may appear in only one or two.

[2] Ingestion of medications was evaluated by a group of physicians; the majority opinion prevailed.

Parkinsonism, L-Dopa, and Intelligence

BY ARMAND W. LORANGER, PH.D., HELEN GOODELL, FLETCHER H. MCDOWELL, M.D., JOHN E. LEE, M.D., AND RICHARD D. SWEET, M.D.

Although many patients with parkinsonism undergo a significant amount of intellectual impairment, several investigators, including the authors, have observed an improvement in intellectual functioning during the first year of treatment with L-dopa. Upon reexamining subjects after 30 months of treatment, however, the authors found that most of their patients did not maintain this improvement. The reasons for the decline are not yet clear, but probably involve the waning influence of L-dopa, the onset or progression of the intellectual impairment common to parkinsonism and the normal aging process, and the impact of other physical illnesses.

WE RECENTLY REPORTED that many people with parkinsonism undergo a significant amount of intellectual impairment (1) and that some of this impairment may be reversed following treatment with L-dopa (2). Approximately half of a group of 40 patients with parkinsonism we studied improved by ten IQ points or more on the Wechsler Adult Intelligence Scale (WAIS) after an average of eight months of treatment. Patients with comparatively low IQs improved more than did those with high IQs. Meier and Martin (3) obtained results virtually identical to ours when they reexamined 39 patients with parkinsonism using the WAIS after only six weeks of treatment, and Beardsley and Puletti (4) reported similar findings after treatment intervals of one and six months. This report concerns our findings when we reexamined many patients with parkinsonism after they had been treated with L-dopa for an average of 30 months.

SUBJECTS

Of the initial group of 40 patients, 24 took the WAIS for the third time after 19 to 44 months of treatment. The average dose of L-dopa remained approximately the same as it had been at the time of the previous examination—4.5 grams daily. The other 16 patients could not be reexamined for various reasons: four had died since their last examination, two had deteriorated so much intellectually that they were unable to take the test, and one patient had been withdrawn from L-dopa because of persistent hallucinations. The remaining nine patients could not be reexamined because they were being treated by other physicians, often in locations that were geographically distant.

Prior to treatment the 24 patients who were examined a third time on the WAIS had not differed as a group from the 16 patients who could not be reexamined in age; sex; education; length of illness; WAIS verbal, performance, and full-scale IQ scores; neurologists' ratings of physical symptoms; or self-ratings of functional disability. Also, the two groups did not differ in the amount of physical improvement they showed during their first year of treatment. However, the 16 patients who subsequently became unavailable for long-term follow-up had shown a greater improvement in performance IQ (13.2 versus 8.5 points, $p < .01$) and full-scale IQ (10.7 versus 7.8 points, $p < .05$) during the first year of treatment.

METHOD

The WAIS IQ scores were calculated using the patients' ages at the time of their initial examination. This was done to avoid an excessive correction for age for patients who passed from one five- or 10-year WAIS age category to another during the course of treatment.

Physical symptoms were assessed by neurologists according to a weighted rating system that measured rigidity, tremors, akinesia, postural abnormality, seborrhea, sialorrhea, blepharospasm, and mask facies. Functional disability was reported by the patients themselves and rated on a weighted scale for degree of difficulty in dressing, eating, walking, getting out of bed, turning in bed, getting out of a chair, climbing stairs, using the toilet, bathing, speaking, and handwriting. The ratings for physical symptoms and functional disability were then converted to standard scores using a distribution in which the mean was 50 and the standard deviation was 10.

RESULTS

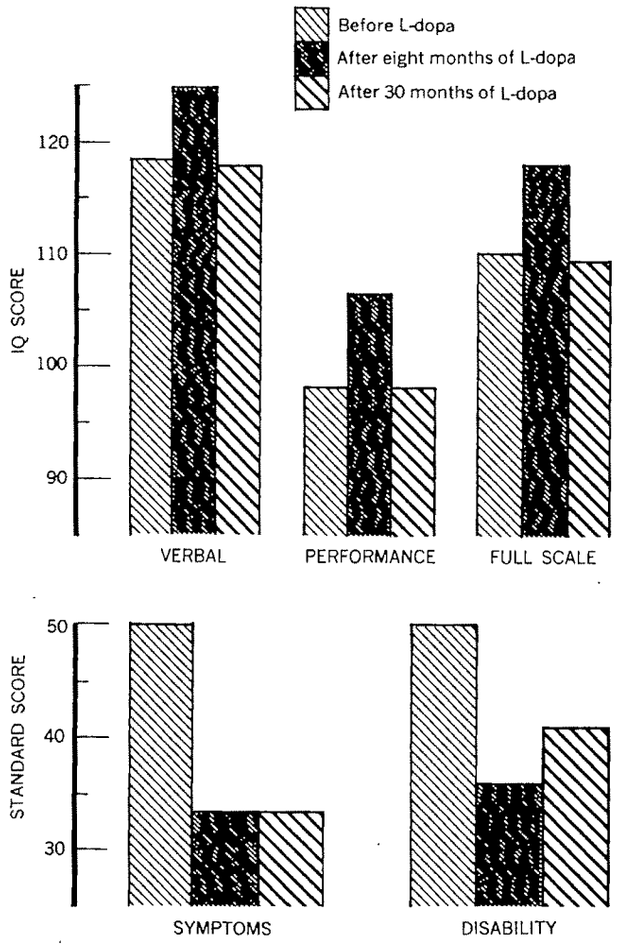
Figure 1 shows the mean WAIS verbal, performance, and full-scale IQ scores of the 24 patients before treat-

The authors are with Cornell University Medical College and the New York Hospital-Cornell Medical Center, New York, N.Y., where Dr. Loranger is Assistant Professor, Department of Psychiatry, and Head, Division of Psychology, Westchester Division, Ms. Goodell is a Research Associate, Dr. McDowell is Professor of Neurology and Associate Dean, Dr. Lee was Associate Professor of Neurology, and Dr. Sweet is Assistant Professor of Neurology; Dr. Lee is now with the Atlanta Neurological Clinic, Atlanta, Ga. Address reprint requests to Dr. Loranger, Department of Psychiatry, New York Hospital-Cornell Medical Center, Westchester Division, White Plains, N.Y. 10605.

This study was supported in part by the American Parkinson Disease Association.

FIGURE 1

Mean IQ, Physical Symptom, and Functional Disability Scores of Patients with Parkinsonism Before and After Treatment with L-dopa (N = 24)



ment and after an average of eight and 30 months of treatment. It reveals that the group lost all of its initial gain in IQ and reverted to a level not significantly different from the level it had shown before treatment. Figure 1 also reveals that the improvement shown by the patients in physical symptoms remained the same as it had been during the first year of treatment but that the patients now reported more functional disability ($p < .01$, by t test), although still substantially less than had been reported before treatment ($p < .001$, by t test).

An examination of the scores of individual patients revealed that, in contrast to the almost universal trend toward improvement shown at eight months, a pronounced trend in the opposite direction occurred during the interval between eight and 30 months. For example, 46 percent of the patients showed an improvement of at least ten points in performance IQ during the first year of treatment, but only a single patient maintained that improvement after an average of 30 months of treatment. In fact, during the period between eight and 30 months, 38 percent of the group declined ten points or more in performance IQ. By the third examination many patients were at the approximate level of their pretreatment scores; others showed varying degrees of increase or decrease.[1]

DISCUSSION

An improvement in WAIS scores during the first year of L-dopa treatment has been observed in three separate studies (2–4). Such increases in scores far exceed those reported in the literature when parkinsonian patients (5) and others (6–8) have been retested after various intervals. This means that the so-called practice effect of repeated test taking is an insufficient explanation for the initial improvement. Ethical considerations prevented us from using a control group of parkinsonian patients treated with placebo, since the efficacy of L-dopa had already been established in two double-blind controlled studies (9, 10). However, the fact that our patients showed approximately the same amount of intellectual improvement after eight months of treatment as after six weeks of treatment would seem to indicate that a placebo effect did not contribute to the improvement, since such an effect might have been expected to diminish after the initial enthusiasm about the treatment subsided.

Although an improvement in physical health could conceivably lead to better intellectual functioning, we found only a slight relationship between physical and intellectual improvement in our original group of 40 patients during the first year of treatment (2). Meier and Martin (3) observed no relationship between improvement on the WAIS and improvement on tests of motor dexterity following L-dopa therapy.

L-dopa can increase both the activity level and learning ability of animals (11–16), but whether such effects are germane to the changes in IQ scores of patients with parkinsonism treated with L-dopa is problematic. However, in the light of evidence that subcortical structures are involved in learning and memory (17, 18), there is at least the possibility that in some patients L-dopa may temporarily enrich dying neurons that are essential for the patient's optimal intellectual functioning.

In order to determine whether the intellectual and physical changes that occurred in individual patients between the eighth and 30th months could be related, we computed product-moment correlation coefficients between changes in the patients' WAIS full-scale IQ scores and changes in their physical symptom and functional disability ratings. The correlation coefficients were .40 ($p < .05$) for physical symptoms and .62 ($p < .001$) for functional disabilities, indicating that a substantial relationship did indeed exist. We also computed correlation coefficients for the intellectual and physical changes that

[1] Full details on changes in scores are available on request from the first author, Dr. Loranger.

occurred over the entire treatment span—that is, from the beginning of treatment to 30 months. These coefficients were .24 ($p > .10$) for physical symptoms and .36 ($p < .05$) for functional disabilities. These findings, of course, do not resolve the question of whether in some cases a worsening of the condition of parkinsonism caused the patient's decline in intelligence or whether both declining health and intelligence were directly traceable to the waning effect of L-dopa.

If the intellectual improvement shown by the patients during the first year of treatment was due to the temporary direct or indirect effect of L-dopa, the patients with the greatest initial increases in IQ scores should tend to be those who showed the greatest decreases during the interval between eight and 30 months. To investigate this we computed a product-moment correlation coefficient between the changes in full-scale IQ scores shown by individual patients after 8 months of treatment and the changes shown by the same patients after 30 months of treatment. The coefficient was $-.35$ ($p < .05$), which confirmed the presence of such a relationship, although it was not a pronounced one.

It is also possible that the intellectual decline experienced by certain patients between eight and 30 months reflected merely the onset or advancement of the intellectual impairment commonly associated with parkinsonism. However, there are two reasons that this explanation should apply to only a limited number of patients. First, there appears to be no relationship between degree of intellectual impairment and duration of the illness, if one allows for the intellectual decline associated with the normal aging process (1). Second, it is highly unlikely that so many patients would, by coincidence, sustain a significant intellectual loss during approximately the same interval. It will be recalled that not a single patient showed such a loss during the first year of treatment.

It is also unlikely that the intellectual decline associated with the normal aging process adequately explains the decline experienced by many of the parkinsonian patients. Interpolation of the WAIS scoring tables (19) indicates that the normal person in the age range of most of our patients declines an average of approximately one full-scale IQ point in one year. Since these normative findings are based on a cross-sectional method, the normal decline associated with advancing age may well have been offset in our patients by the practice effect of taking the test on three occasions. A longitudinal study by Eisdorfer (7) provided some support for the existence of such a practice effect—he found that there was a mean full-scale IQ increase of 2.3 points in a group of 165 elderly people living in the community when he reexamined them on the WAIS after an average interval of 3.5 years. However, Birren (8) reported a mean decrease that was equivalent to 5.7 full-scale IQ points when he retested 29 men who were over 65 years of age after an interval of approximately five years. In any event, there is no precedent in either cross-sectional or longitudinal studies for a mean decline of 8.0 full-scale IQ points in an average period of only 22 months.

Several patients showed particularly pronounced decreases between eight and 30 months; their full-scale IQs declined between 15 and 40 points. Birren (8) has observed that such declines are somewhat more common for elderly people who have physical illnesses than for those who are healthy. It should be noted in this regard that four parkinsonian patients developed significant illnesses in addition to their parkinsonism after their first year of treatment with L-dopa. One patient died of a myocardial infarction several months after his third WAIS examination; he had shown a decline of 40 points in full-scale IQ. Three patients developed prostate disease; they showed declines of nine, 13, and 27 points. Thus, as a group, these four patients declined substantially more than did the others.

Admittedly, the reasons for both the initial intellectual improvement shown by our patients following treatment with L-dopa and for their subsequent intellectual decline remain a matter for conjecture. However, the bulk of the evidence does seem to suggest that much of the initial improvement was directly or indirectly due to L-dopa; the later decline was probably caused by the waning influence of L-dopa, the onset or progression of the intellectual impairment common to parkinsonism and the normal aging process, and the impact of other physical illnesses. Certain of these factors undoubtedly played a greater role in the decline of individual patients than did others.

REFERENCES

1. Loranger AW, Goodell H, McDowell FH, et al: Intellectual impairment in Parkinson's syndrome. Brain 95:405–412, 1972
2. Loranger AW, Goodell H, Lee JE, et al: Levodopa treatment of Parkinson's syndrome: improved intellectual functioning. Arch Gen Psychiatry 26:163–168, 1972
3. Meier MJ, Martin WE: Intellectual changes associated with levodopa therapy. JAMA 213:465–466, 1970
4. Beardsley JV, Puletti F: Personality (MMPI) and cognitive (WAIS) changes after levodopa treatment. Arch Neurol 25:145–150, 1971
5. Asso D, Crown S, Russell JA, et al: Psychological aspects of the stereotactic treatment of parkinsonism. Br J Psychiatry 115:541–553, 1969
6. Berkowitz B, Green RF: Changes in intellect with age, V: differential changes as functions of time interval and original score. J Gen Psychol 107:179–192, 1965
7. Eisdorfer C: The WAIS performance of the aged: a retest evaluation. J Gerontol 18:169–172, 1963
8. Birren JE: Increments and decrements in the intellectual status of the aged. Psychiatr Res Rep Am Psychiatr Assoc 23:207–214, 1968
9. Cotzias GC, Papavasiliou PS, Gellene R: Modification of parkinsonism: chronic treatment with L-dopa. N Engl J Med 280:337–345, 1969
10. Yahr MD, Duvoisin RC, Schear MJ, et al: Treatment of parkinsonism with levodopa. Arch Neurol 21:343–354, 1969
11. Strömberg U, Svensson TH: L-dopa induced effects on motor activity in mice after inhibition of dopamine-beta-hydroxylase. Psychopharmacologia 19:53–60, 1971
12. Maj J, Grabowska M, Mogilnicka E: The effect of L-dopa on brain catecholamines and motility in rats. Psychopharmacologia 22:162–171, 1971
13. Kellogg C, Lundborg P: Ontogenic variations in responses to L-dopa and monoamine receptor-stimulating agents. Psychopharmacologia 23:187–200, 1972
14. Stahl SM, Zeller EA, Boshes B: On the effect of modulation of

cerebral amine metabolism on the learning and memory of goldfish (Carassius auratus). Trans Am Neurol Assoc 96:310–312, 1971
15. Seiden LS, Peterson DD: Reversal of the reserpine-induced suppression of the conditioned avoidance response by L-dopa: correlation of behavioral and biochemical differences in two strains of mice. J Pharmacol Exp Ther 159:422–428, 1968
16. Ahlenius S, Andén NE, Engel J: Importance of catecholamine release by nerve impulses for free operant behavior. Physiol Behav 7:931–934, 1971
17. Ojemann GA, Blick KI, Ward AA Jr: Improvement and disturbance of short-term verbal memory with human ventrolateral thalamic stimulation. Brain 94:225–240, 1971
18. Peeke HVS, Herz MJ: Caudate nucleus stimulation retroactively impairs complex maze learning in the rat. Science 173:80–82, 1971
19. Wechsler D: Manual for the Wechsler Adult Intelligence Scale. New York, Psychological Corporation, 1955

Interaction of Hypnotic Suggestion and Alpha Enhancement

BY T.A. TRAVIS, M.D., C.Y. KONDO, M.A., AND J.R. KNOTT, PH.D.

Eight subjects who underwent a standardized hypnosis induction procedure before receiving alpha-enhancement training were compared with eight subjects who were given only the alpha-enhancement training. The hypnosis group did not produce significantly more alpha activity during feedback than they had during a baseline period and they produced significantly less alpha activity during the last three training sessions than the matched group of no-hypnosis controls. Differences between the results of this study and the findings of others are discussed in terms of the adequacy of the techniques involved.

IT HAS BEEN REPORTED that persons with high scores on tests of hypnotic susceptibility tend to produce more alpha activity in their EEGs than persons with low scores (1, 2). Engstrom and associates (3) have stated that feedback training that increases the abundance of alpha activity in the EEG increases hypnotic susceptibility. Studies of the subjective responses of subjects given such alpha training (4–6) report that the experience is pleasant and relaxing. Since procedures used to induce hypnosis tend to produce similar "states," it was hypothesized that the induction of hypnosis in conjunction with alpha-enhancement training would result in greater production of alpha than that resulting from biofeedback training alone.

At the time this paper was written, the authors were all with the Department of Psychiatry and EEG and Neurophysiology, University of Iowa College of Medicine, Iowa City, Iowa, where Dr. Travis was Assistant Professor, Mr. Kondo is Research Associate, and Dr. Knott is Professor; Dr. Travis is now Associate Professor of Psychiatry, Southern Illinois University School of Medicine, Springfield, Ill. 62708.

This work was supported in full by the Iowa Mental Health Research Fund.

METHOD

Our subjects were 16 male students, staff members, and employees of the University of Iowa (ages 22–44) who volunteered to participate in experiments involving occipital alpha enhancement by biofeedback and/or hypnosis. The subjects were divided into two groups: hypnosis (N=8) and no-hypnosis controls (N=8). All subjects were studied in a dimly lit, sound-controlled room with a temperature range of 73–79F.

Silver-silver chloride electrodes were applied to each subject's head with collodion-soaked strips of gauze; they were placed as follows: 1) 2 cm. above the inion (O_Z), 2) on the right ear or mastoid, 3) at the vertex (C_Z), 4) above and below the right eye, and 5) on the forehead (ground).

The following leads were monitored: 1) O_Z–ear/mastoid (alpha), 2) eye electrodes (eye movements), and 3) C_Z–ear/mastoid (this is the index of drowsiness; the vertex is the peak gradient for K complexes of sleep). One subject who became drowsy (a member of the hypnosis group) was replaced with an alternate.

A Grass model 78 polygraph was used for recording. Occipital alpha was recorded using a wide-band model 7P5 preamplifier. The output (at J6) of this amplifier was filtered for alpha activity at 8–13 Hz. using a twin-T band-pass filter. Signals outside of the 8–13 Hz. band were attenuated by 80 percent. This output was then fed to a 7P3 integrator that led to level detectors (which controlled the feedback stimulus), cumulative timers, and a signal marker on the polygraph.

Alpha-enhancement training was given to all subjects. The electrodes were applied and impedence was kept below 5 kilohms. Our subjects received the feedback (a blue light) only when they equaled or exceeded a predetermined level or criterion of alpha. *Criterion alpha* was defined as follows: 0.07 to 0.13 seconds of activity at 8–13 Hz. that registered as 50 percent or more of the amplitude of the maximum eyes-closed alpha observed during an initial calibration period. The subjects were given the following instructions after the electrodes were placed:

> The blue light indicates that you are producing alpha. Your task will be to find a method to turn the light on and then keep it on for as long as possible. You will be given five eyes-open training sessions to practice control of alpha. After each eyes-open practice session there will be a two-minute period during which you are to relax and close your eyes.

In addition, subjects were warned that muscle tension and movement could turn on the light and that this would be inappropriate for the purposes of the study. They were asked, therefore, to refrain from such activities as much as possible.

Hypnosis Group

The subjects in this group were tested twice, with approximately seven days between each test session. On day 1, baseline EEG data were obtained with no hypnosis and no feedback. The subjects sat with their eyes open for five ten-minute periods, alternating with their eyes closed for five two-minute periods. They were instructed to relax and remain awake. On day 2, a standardized hypnosis induction procedure was administered before alpha training began. A modification of a procedure described by Elman (7) was used. The subjects were instructed to tightly close their eyelids, then to gradually relax them, allowing the feeling of relaxation to spread from their eyelids throughout their bodies. The entire procedure lasted seven to ten minutes. Included in the procedure were suggestions that the subjects would feel "pleasant, relaxed, floating," terms that had been used by some of our previous subjects in alpha enhancement studies to describe their subjective feelings. Following hypnosis, these subjects received the same alpha enhancement training as the no-hypnosis controls.

No-Hypnosis Controls

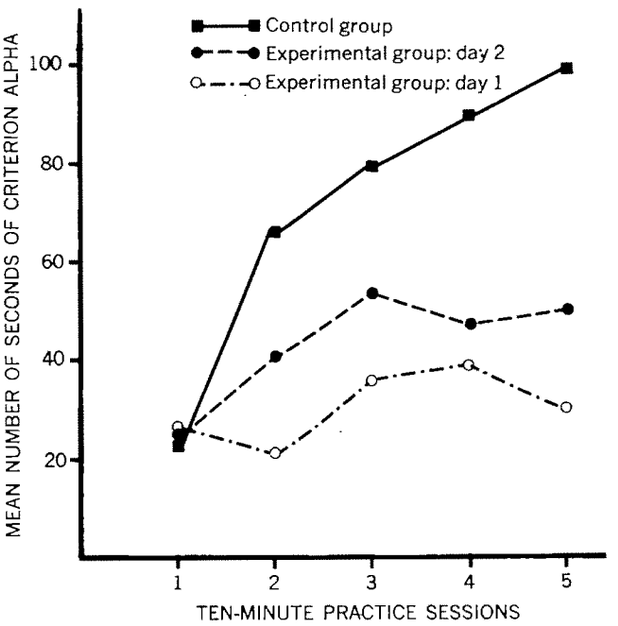
These subjects were matched with the hypnosis group on the basis of the abundance of alpha emitted during the first reinforcement practice session. Care was taken to ensure that the initial alpha amplitudes and abundances of the experimental and control groups were similar (8). The no-hypnosis controls received five ten-minute feedback sessions, as described above.

RESULTS

The mean performance of the hypnosis group on days 1 (baseline) and 2 (hypnosis and feedback) and of the no-hypnosis controls is shown in fugure 1.

FIGURE 1

Comparison of Mean Number of Seconds of Criterion Alpha Activity Emitted per Ten-Minute Session



The group that received hypnosis produced no more criterion alpha with feedback than they had during the baseline period ($F < 1.0$). No significant changes in criterion alpha were noted during the baseline period.

In general, the no-hypnosis controls did not produce significantly more criterion alpha with feedback than did the hypnosis group ($F=3.1243$; $df=1,14$; $p > .10$). An analysis of simple effects using the method of critical differences revealed, however, that the no-hypnosis controls produced significantly more criterion alpha during sessions 3, 4, and 5 than did the hypnosis group ($p < .05$). A significant change in alpha production for the combined groups over trials was noted ($F=7.15868$; $df=4,56$; $p < .01$) and an analysis of the changes over trials for each individual group revealed that both groups produced significantly more criterion alpha activity during feedback in session 5 than in session 1 (although only at the marginal $p < .05$ level).

DISCUSSION

If one argues that some functional relationship exists between the enhancement of feedback and hypnosis, then we should have found a relationship between the experience of hypnosis and higher alpha production. Our results, however, indicate that a hypnosis procedure does not potentiate alpha enhancement using visual feedback.

There are technical differences between the alpha-enhancement methods of Engstrom and associates (3) and

our procedures. First, they used two sets of feedback stimuli, one a series of light flashes synchronous with "*all frontal brain waves*" (italics ours) and the other a discontinuous tone activated by occipital alpha. If the frontal activity was at the alpha rate, then such a stimulus would tend to "drive" (i.e., artificially elicit) the occipital alpha (9). Thus, the alpha "enhancement" obtained by such a technique is open to question. If the light flashes were not synchronous with occipital alpha, they would have a complex effect upon any occipital activity so that the emitted tone would not be related to the flashing light.

Another major methodological difference exists between the two studies. Engstrom and associates used a frontal site with an ear reference (A_1) rather than an occipital–ear reference. Referential recording is notoriously dangerous unless the reference is clearly known, in each instance, to have no activity in its locality. Unfortunately, a broad occipital alpha gradient does spread into the A_1 (left ear) electrode. Alpha activity does not appear as a dominant rhythm in the frontal region when closely spaced electrodes are used to differentiate the frontal from the occipital alpha field. This point has been thoroughly discussed by Walter (10). It is indeed doubtful whether the measure utilized by Engstrom and associates is valid to test the hypothesis that alpha enhancement and hypnotic suggestibility are in any way correlated.

REFERENCES

1. London P, Hart J, Leibovitz M: EEG alpha rhythm and susceptibility to hypnosis. Nature 219:71–73, 1968
2. Galbraith G, London P, Leibovitz M, et al: EEG and hypnotic susceptibility. J Comp Physiol Psychol 72:125–131, 1970
3. Engstrom DR, London P, Hart JT: Hypnotic susceptibility: increased by EEG alpha training, in Biofeedback and Self-Control. Edited by Barber T, DiCara L, Kamiya J, et al. Chicago, Aldine/Atherton, 1970, pp 262–265
4. Brown BB: Recognition of aspects of consciousness through association with EEG alpha activity represented by a light signal. Psychophysiology 6:442–452, 1970
5. Brown BB: Awareness of EEG-subjective activity relationships detected within a closed feedback system. Psychophysiology 7:451–464, 1971
6. Kamiya J: Operant control of the EEG alpha rhythm and some of its reported effects on consciousness, in Altered States of Consciousness. Edited by Tart CT. New York, John Wiley & Sons, 1969, pp 507–519
7. Elman D: Findings in Hypnosis. Clifton, NJ, Dave Elman, 1946, pp 98–99
8. Kondo CY, Travis TA, Knott JR: Initial abundance and amplitude of alpha as determinants of performance in an enhancement paradigm (abstract). Electroencephalogr Clin Neurophysiol 34:106, 1973
9. Adrain ED, Matthews BHC: The Berger rhythm: potential changes from the occipital lobes in man. Brain 57:355–385, 1934
10. Walter WG: Techniques-interpretation, in Electroencephalography: A Symposium on Its Various Aspects. Edited by Hill D, Parr G. London, Macdonald & Co, 1950, pp 65–98

Legal and Illegal Use of Methadone: One Year Later

BY RICHARD C. STEPHENS, PH.D., AND ROBERT S. WEPPNER, PH.D.

This study (which replicated one conducted a year earlier) found that the use of methadone, both legal and illegal, had increased. The role of the pusher as supplier of illicit methadone declined, while other suppliers, particularly addict friends, became more important. The reasons for the use of illicit methadone changed dramatically; methadone's low cost and ease of procurement aided its emergence from a substitute drug to a drug of choice. The study seems to indicate that the black market in methadone was flourishing and had possibly grown in the short span of one year.

IN 1971 a study of some aspects of the legal and illegal use of methadone was conducted (1). This study employed as subjects patients of the National Institute of Mental Health Clinical Research Center (CRC) who had used methadone before their admission. The present study is a replication of the 1971 study and also uses CRC patients who were admitted and interviewed approximately one year later. The study was undertaken with one chief goal in mind—to determine if changes had occurred in methadone use patterns in the year when methadone and methadone maintenance had become national issues.

In any kind of comparative analysis such as the one carried out here, one must always be wary that any changes noted are due not to the variables themselves but rather to underlying changes in the study populations.

Dr. Stephens is Deputy Director of Research, New York State Narcotic Addiction Control Commission, 1855 Broadway, New York, N.Y. 10023. Dr. Weppner is Director of Research, Division of Addiction Sciences, Department of Psychiatry, University of Miami Medical School, Miami, Fla.

TABLE 1
Comparison of Overall Addict Populations with Subjects Who Used Methadone

Group	Number	Median Age (Years)	Median Length of Addiction (Years)	Median Years of Education	Median Number of Arrests	Sex (Percentage) M	Sex (Percentage) F	Race* (Percentage) B	Race* (Percentage) W	Race* (Percentage) O
Overall population										
1971 admissions	1,955	23	3	11	4	81	19	60	37	3
1972 admissions	743	23	4	11	4	78	22	49	46	5
Addicts using methadone										
1971 admissions	213	23	3	11	5	83	17	59	39	2
1972 admissions	350	24	4	11	5	80	20	49	47	4

* "B" represents black subjects, "W" white subjects, and "O" other subjects.

Never is this more true than when one views two samples of patients admitted at different times to a psychiatrically oriented hospital. Admission criteria, as well as the kinds of patients that the hospital attracts, could have changed. As more and more local programs come into existence, there is the additional concern that a hospital such as the CRC might attract a very biased sample.

Table 1 presents a comparison of the first admissions to Lexington in 1971 and 1972. The data for most of the demographic variables did not change; only two noteworthy differences emerged. First, the number of first admissions dropped from 1,955 in 1971 to 743 in 1972. This decrease reflected both the growth of local treatment facilities alluded to earlier and the federal effort to contract for local services for patients who formerly would have been admitted to Lexington. The second major difference was ethnicity: fewer blacks and more whites were seen in the later group. While this change was a relatively large one, its significance will shortly be shown to be minor.

STUDY DESIGN

As already noted, this study is a replication of the 1971 study. All the subjects were narcotic addicts admitted to the CRC, whose catchment area is described elsewhere (1). After admission and withdrawal from narcotics, all patients are interviewed by experienced interviewers using the Lexington Social Data Form. If, at the time of the interview, the patient noted that he had at some point used methadone—in a maintenance program, a detoxification program, or illegally—a special methadone questionnaire was administered.

A total of 336 persons had been admitted during the 1971 study period.[1] A total of 469 persons were admitted during the later study period.[2] Of the 336 persons, 63 percent (213) had had some previous experience with methadone; 43 percent (145) had used it illegally, 33 percent (111) had been in a maintenance program, and seven percent (24) had used it only in the context of legally approved detoxification. In the sample described here, 75 percent (350) had some experience with methadone (legal or illegal), and 52 percent (242) had used it illegally. Twenty-seven percent (128) had been enrolled in a maintenance program and 20 percent (94) had used it *solely* in the context of legally sanctioned detoxification. What we see, therefore, is an increase in the amount of illegal use in the streets and an increase in the use of methadone for detoxification. The first finding seems to fit in with what is becoming increasingly obvious—significant amounts of methadone are being directed into illegal channels. The second finding, that use of methadone for detoxification is increasing, also seems consistent with the impression that its use in jails and treatment centers is becoming more widespread. The fact that a smaller percentage of the patients had been enrolled in maintenance programs was unexpected; the drop in percentage, however, was insignificant.

Table 1 also shows that the demographic characteristics of those who have had experience with methadone have not changed. In fact, comparison of the appropriate columns in table 1 indicates that the methadone sam-

TABLE 2
Sources of Illegal Methadone in 1971 and 1972

Source	1971 (N=145) Number	1971 (N=145) Percent	1972 (N=242) Number	1972 (N=242) Percent
Regular pusher	64	44	73	30
Methadone maintenance program	54	37	85	35
Program (stealing, etc.)	0	0	1	1
Pharmacy	5	3	10	4
Physician ("conned" by addict)	3	2	15	6
Physician (other than those "conned" by addict)	4	3	8	3
Miscellaneous sources	15	10	50	21

[1] All subjects admitted between April 30 and August 3, 1971.

[2] All subjects admitted between May 23 and October 18, 1972.

TABLE 3
Reasons Given for Illegal Use of Methadone, Given in Percentages

Reason	1971 Sample (N=145)	1972 Sample (N=242)
Positive qualities of methadone		
Duration of euphoria	3	1
Quality of the "high"	8	8
Ease of procurement	9	15
Low price	9	38
Experimenting	0	7
Total	29	69
Methadone as a substitute drug		
To try to kick the habit	34	12
To keep from being sick	9	5
No other narcotics available	12	7
To reduce the size of the habit	10	3
Total	65	27
Other	6	4

ples reflect the characteristics of the admission populations from which they came. Thus, the conclusion drawn from the 1971 study that the average methadone user is not significantly unlike the average Lexington patient remains true today. It is appropriate to also point out that, although the percentage of blacks decreased in the general Lexington population, their representation as methadone users in proportion to their numbers in the population for 1972 remained the same.

ILLEGAL USE OF METHADONE

In the 1971 study the subjects reported their daily dosage of illegal methadone and its cost. The 1972 study revealed little change for these two variables. The estimated median daily dosage rose from 50 mg. to 60 mg., while the median daily cost dropped from $4 to $3. One might speculate that the increased dosage coupled with decreased cost may be due to a greater supply of illicit methadone on the streets. Such an interpretation is supported not only by findings such as these but by stories from the street as well. One patient, who diverted methadone from the program in which he was employed, reported there was so much illicit methadone on the streets of Washington, D.C., that he had found it difficult to find customers.

Although the cost and the size of the dosage showed little change, there was a significant shift in the sources from which the patient obtained his illicit methadone. Table 2 shows that the regular heroin pusher became a less important source in the 1972 sample. It appears that fewer people went to the pusher directly, preferring instead to obtain methadone in a more circuitous way. Most of the "miscellaneous" category consisted of other addict friends who obtained methadone from a pusher, by "making doctors," robbing pharmacies, or by other ways.

Some of the most significant changes, in both a statistical and a social sense, are found in table 3, where the reasons for patients' use of illicit methadone are noted. The percentages are completely reversed. Whereas in 1971 almost two-thirds of the patients used methadone as a substitute drug, in 1972 over two-thirds reported using methadone because of its positive qualities. (The small "other" categories consisted of responses that did not fit elsewhere.) Most noteworthy is the fact that low price and ease of procurement—both in all likelihood related to abundant supply—were the chief reasons for the use of methadone. These figures serve only to further underscore what was noted in the 1971 study:

> They indicate that there may be a significant number of addicts turning to illegal methadone as a drug of choice, thereby creating a new and important class of narcotic abuser. Further, illicit diversion from maintenance programs may be helping to increase the numbers of this kind of addict (1, p. 454).

In summary, there appears to be a confluence of elements that create a situation worthy of concern. First is the apparently widespread availability of illicit methadone, probably spawned by inadequately controlled programs. To this situation must be added the increasingly higher prices and poorer quality of heroin on the streets. Finally there is the fact that methadone, especially in its

TABLE 4
Percentages of Patients Who Reported Abusing Other Drugs While in Methadone Maintenance Programs (N for 1971=111, N for 1972=128)

Drug	Addicted*		Abused Fairly Often		Abused Once or a Few Times		Total**	
	1971	1972	1971	1972	1971	1972	1971	1972
Heroin	22	23	5	9	32	16	59	48
Illicit methadone	0	19	1	3	0	5	1	27
Other narcotics	0	3	2	2	6	6	8	11
Cocaine	0	6	10	6	18	10	28	22
Sedatives, hypnotics, and relaxants	4	8	3	7	11	5	18	20
Stimulants	3	2	0	3	6	3	9	8

* The subject abused the drug regularly enough to become addicted.
** Totals add up to more than 100 percent since individual respondents may have reported abuse of more than one drug.

nonliquid form, is a higher quality drug than street drugs. The addict knows the potency of the drug he is buying when he purchases methadone. In other words, as some addicts have told us, methadone is stronger and more dependable and its "high" may be just as good. All of these factors point to the emergence of methadone not only as a significant drug of abuse but as a new and potentially important drug of choice as well.

PARTICIPATION IN METHADONE MAINTENANCE PROGRAMS

Also examined in the 1971 study were factors surrounding participation in maintenance programs. As noted, 27 percent (128) of the 1972 sample had participated in such programs. These patients spent a median of 122 days on maintenance, which was twice the figure reported for the 1971 sample. For those who reported they knew their daily dosage (and 80 percent said they did), the median dosage was computed to be 80 mg. This figure is almost the same as for the 1971 sample.

The 1971 study assessed the use of proscribed drugs outside the methadone regimen among the maintenance patients. This figure was 78 percent in 1971 and 79 percent in 1972. Table 4 presents the kinds of drugs used and the extent of abuse for both the 1971 and 1972 samples. Several findings emerge. First, with the exception of illicit methadone, the total percentages of people abusing specific types of drugs either remained the same or decreased. For instance, the percentage of persons who abused heroin dropped from 59 percent in 1971 to 48 percent in 1972. Possible interpretations for this decline in use of street drugs include the poor quality and thus the diminished desirability of the traditional street drugs, a shift to supplementation with other drugs such as methadone, and a tightening of maintenance program procedures so that the opportunities for supplementation were lessened for many clients.

Second, it should be noted that while the percentages of subjects abusing most classifications of drugs dropped, the percentage of abuse still remained high. Third, although the percentages of people using illegal drugs at least once stabilized or dropped, the percentages who regularly used them increased slightly. This is true for every drug class noted and constitutes grounds for further attention. Fourth, the use of illicit methadone for supplementation notably increased. Twenty-two percent of the supplementers reported using additional methadone fairly regularly. Four-fifths of these regular supplementers reported that they did so either because they wanted to get high or because they *liked* methadone.

The foregoing must be tempered by the fact that all patients represented in table 4 were in fact no longer participating in methadone maintenance programs. Being *former* methadone maintenance patients, they were to some extent methadone maintenance *failures*; the figures are not representative of patients currently in methadone maintenance programs. Nevertheless, these findings point to the fact that supplementation still does occur in some programs at undetermined levels. Further, the apparent growth of a black market in methadone has made it a noteworthy drug of abuse even for maintenance patients.

REFERENCE

1. Weppner RS, Stephens RC, Conrad HT: Methadone: some aspects of its legal and illegal use. Am J Psychiatry 129:451–455, 1972

Family Structure in Three Cases of Anorexia Nervosa: The Role of the Father

BY PATRICIA WOLD, M.D.

The family structure in three cases of anorexia nervosa is described. Each parent placed a daughter (the patient) in the position of his or her own mother, toward whom neither parent could express hostility. This conflict was focused on the child, blocking any expression of aggression or sexuality in the child. The actual weight loss seemed closely related to the patient's relationship with her father.

A REVIEW of the extensive literature concerning anorexia nervosa emphasizes early deprivation leading to a lesion in ego structure (1–4), the parents' focus on food (2–4), the symbolism of food (3, 4), a rejection of sexuality with the effect of starvation on the libido (1, 4–6), and the re-

Dr. Wold is Medical Director, East Providence Mental Health Clinic, East Providence, R.I. Her address is 66 Pitman, Providence, R.I. 02906.

gression to an earlier level of functioning, with oral pregnancy fantasies (3–6). There have been few detailed studies of the entire family structure.

This paper describes three cases, two of which are classical; the third probably represents an abortive case illustrating a symptom choice other than anorexia nervosa.

CASE REPORTS

Case 1. This 14-year-old premenarchal girl experienced a ten-pound weight loss at camp when a low level of supervision allowed sexual encounters between boys and girls at night in the patient's cabin; this was very frightening to her. The family history revealed that the patient's mother had experienced a depression that required treatment when the patient was one year old. The patient had suffered severe separation anxiety at the age of three when she was sent to nursery school; she was taken out of school and kept at home. She had had similar difficulties the next year in kindergarten.

The patient's mother, youngest of three, was the "baby" in her family. The maternal grandmother was a dominating woman who easily exploded with anger. The patient's mother was like the maternal grandfather, who was described as a quiet man. The patient's mother could not discuss sex or any other problems with the maternal grandmother and was unable to refuse her a favor. The maternal grandmother, who was obese and always dieting, had a diaphragmatic hernia that caused numerous stomach complaints. She controlled the patient's mother by having a "heart attack" when she was not catered to. The mother felt that she could not talk to the maternal grandfather lest he "fall apart." When depressed, the patient's mother liked to cook for others. When the patient's father was not on time for dinner, the mother became furious; there were many quarrels. The patient's mother was afraid of her husband's temper and felt she was being compared unfavorably with her mother-in-law.

The patient's father, a hardworking, successful businessman, had a hot temper; when he was enraged at the patient's depression and refusal to eat, he hit her hard enough to cause bruises. The paternal grandfather was a depressed man and had been unable to work for years; the father and his two brothers had been supported by the paternal grandmother's earnings. She was idolized by the patient's father and it was she whom the patient reminded him of. The father and his brothers had been forbidden to express any disrespect toward their mother, and this was enforced by strapping by their father, who had helped care for them while their mother worked.

The patient's father could not tolerate the patient's expressing any disrespect toward her own mother. If she misbehaved, her mother would threaten that her father was coming. The parents chronically fought at the dinner table, usually over the father's being late for dinner or having to return to work. Two years before the onset of the patient's symptoms these fights were focused on the way the patient held her fork. She had been afraid that her father would kill her mother during their arguments and was aware of holding her fork awkwardly on purpose to focus attention on herself. The patient expressed the feeling that the fights were her fault and that if her parents divorced it would also be her fault. She expressed a fear of marriage, feeling that it would lead to divorce and that she could not be a good mother.

At the onset of her illness, the patient was severely depressed and would bang her head on the floor or wall to the extent of causing bruises; she also heard voices telling her to kill herself. Her weight went down to 65 pounds. She was put on a regimen of chlorpromazine (Thorazine) and desipramine hydrochloride (Norpramin). While the patient was hospitalized her father agreed to participate in family sessions. The patient began to gain weight and began to date a boy her own age. As material relating to the patient's mother's relationships with the maternal grandmother came up the father unilaterally withdrew from treatment, creating tension between the parents. Within two weeks the patient began to lose weight. When the therapist insisted, the father decided to seek another therapist and again entered therapy. The patient again gained weight and was able to discuss some of her sexual fantasies more openly.

Case 2. This patient became ill at age 13 following a verbal attack from her father. The father had had a hernia operation and the mother had spent much of her time at the hospital. As he was recuperating, the patient's maternal grandfather had a stroke, so the mother was again at the hospital. The patient was put under great pressure by her maternal grandmother and by her father to help with the housework. After her father had verbally attacked her, she became depressed and withdrawn and her weight dropped to 65 pounds. Her menstrual periods stopped.

The mother, a middle child, had suffered a depression after the patient's birth. Throughout the patient's early years her mother was often in bed, depressed and anxious and unable to function. She was a compulsive eater who was constantly on a diet. The patient's mother was dominated by her own mother, who telephoned many times a day and constantly nagged her about her weight. The patient's mother was unable to refuse her own mother's demands. The maternal grandmother also dominated her husband, who was described as quiet. The patient's mother was said to be "too nice." She would not fight with the patient, but if the patient became angry she told her husband. She was afraid to defend the patient from the father's verbal abuse lest this lead to a divorce. She responded to the patient as she did to her own mother. Once when the patient was four years old, her mother became anxious about the whereabouts of her son and was afraid she was going to faint. She called the patient in from play and had her make phone calls for her.

The patient's father, a physician, was compulsive and stingy with money. The paternal grandfather was a poor immigrant who was described as quiet. The patient's father, one of four children, idolized his mother, who was described as petite and capable and was said to have "worked herself to death." The patient felt that this was what was expected of her. (She was born right after her father's mother's death and physically resembled his side of the family.) When his wife became ill, the patient's father did the housework. He made many verbal attacks on the patient, calling her lazy and sloppy. The patient felt that she was regarded as dirty. If she fought with her mother, her father's response was: "Don't upset your mother." He praised the patient only for her grades.

Case 3. This patient, a 14-year-old girl who had two sisters aged 12 and four, was brought to the doctor because of a ten-pound weight loss following a physical attack by her father. Her paternal grandmother, who had been visiting, had insisted on trying a dress on the patient, who expressed resentment by a defiant shrug of the shoulders. The father was enraged and physically beat her, knocking her about the room. Following this the patient began to spend a lot of time in her room playing with dolls. She lost ten pounds and was obviously depressed.

The maternal grandmother had a neurological disorder and had been ill most of the patient's mother's life. The mother's family had lived with the maternal great-grandmother until the

mother was ten years old. The maternal grandfather was the dominant parent; he was stricter with his older daughter than with the patient's mother. He stayed out of fights with his wife and mother-in-law. The patient's mother was never allowed to show anger; she was told that she must say only pleasant things. She never went out, she was chronically depressed and compulsive, and she was always cleaning the house.

Two years before the patient's illness, the maternal great-grandmother moved in with the maternal grandmother. The patient's mother was completely dominated by the great-grandmother, wearing what she told her to wear and setting aside her own plans to run errands for her. The maternal great-grandmother focused much attention on food. The patient's mother reacted by eating little. She was unable to set limits with the patient. She allowed her to stay out of school and go places with the maternal great-grandmother or with a boyfriend. If the patient had a problem, the mother reacted by crying.

The father was a compulsive, hardworking salesman. His parents had been divorced when he was eight years old. The paternal grandfather was passive and the father was still dominated by his mother, who gave unwanted advice and tried to buy love with gifts. He could not refuse her or allow anyone in the family to do so; she reacted with tears to any resistance to her wishes. The father was also unable to disagree with his boss at work. He and his wife disagreed over money and his need for new cars. He had a temper and would throw things around the room when angry. He was described as seductive toward his daughters.

For the first six months of the patient's life the family lived with the paternal grandmother, where the patient's mother was very unhappy. Two years before the patient's illness it is likely that she overheard her mother and aunt talking about an affair that the father might have had with a waitress; the mother and aunt agreed that "men are lousy." This incident seemed to coincide in time with the patient's going to coffeehouses and kissing boys for the first time; she later felt guilty about this. The patient was also caught shoplifting twice.

The patient's periods had started when she was 12 years old; they stopped at the time of the weight loss. When therapy started, she slowly gained weight and her periods resumed. Shortly after therapy began, she came home with a "hickey" from necking with a boy. Her father went into a rage but did not physically attack her. She experimented with drugs and became involved with an older boy. At a point when he seemed to reject her, she cut her wrists and was hospitalized; a regimen of antidepressants and phenothiazines was instituted. She returned to school but felt she couldn't handle it. Her father supported her with an offer to send her to a private school, against the mother's resistance. She began to do well in school for the first time since her illness and seemed able to discuss her feelings with her parents.

DISCUSSION

All of the mothers of these girls had experienced depression during the patients' formative years, providing the background of emotional deprivation that seems to be a necessary condition for the syndrome of anorexia nervosa. The mothers were unable to separate from their own mothers and could not refuse them favors. The maternal grandmothers (in case 3, the maternal great-grandmother, who was the mother surrogate for the patient's mother for the mother's first ten years) were very concerned about dieting. The mothers recreated their relationship with their mothers with the patients. This was particularly clear in case 2 when the mother called on her four-year-old daughter to make phone calls that she was too anxious to make. In not eating, the patients were obeying the unspoken command to be like their maternal grandmothers.

The mothers were unable to deal with their anger by setting limits and tried to please instead, thus creating guilt if any anger was expressed. They were described as being "too nice." They handled aggression on the part of the patient by crying, thus threatening to "fall apart" or leave the patient by going into a depression, and by threatening to tell the father; this discouraged a positive relationship between the patient and the father.

All the fathers were rigidly compulsive persons with violent tempers. All had been raised by mothers who dominated their husbands and who insisted on absolute obedience and respect from their sons. They did not tolerate aggression toward themselves. These men also could not refuse favors to their mothers. Sex was not discussed in these families, and the men gave the impression of being devoted to their families. Case 3 was different in this respect; here the father was more openly sexual and was described as seductive toward his daughters. Knowledge of his sexuality seems to have given this patient permission to involve herself with boys sexually, satisfying some of her craving for closeness. It was only after a physical attack by her father that she withdrew and began to lose weight. As her father's attitude changed, she gained weight and turned again to heterosexuality. The wrist-cutting episode followed her rejection by a boyfriend, but there was no weight loss.

Each of these fathers seemed to identify the patient with his mother and to focus on his daughter the hostility he had never been able to express directly to his mother; this prevented the daughter's normal heterosexual development. In case 1 the weight loss and gain paralleled the involvement of the father in treatment. In case 2 the weight loss first occurred after a verbal attack by the father. In case 3 the weight loss first occurred after a physical attack by her father when the patient expressed the hostility toward his mother that he could not express.

Emotional deprivation seems to be a necessary but not a sufficient condition for the development of anorexia nervosa. The craving for affection may be handled by heterosexual acting out if this is not blocked by the father. The child who develops anorexia nervosa seems to specifically represent to the father his own mother (which perhaps explains why we do not hear of more than one case in a family) and the maternal grandmother to the mother.

Neither parent can tolerate aggression; thus both aggression and sexuality are completely blocked. The mother seems to be a willing accomplice in focusing the father's hostility on the child rather than on herself; she threatens to fall apart and to tell the father if aggression is expressed toward herself. This seems related both to the mother's fear of possible separation or divorce and to her competitive feelings due to the perception that the child represents the paternal grandmother to the father. In cases 1 and 2 the patients seemed aware of their

expected role in preventing divorce: the patient in case 1 said a divorce would be her fault and she deliberately behaved so as to be yelled at in the hope that the parents would not fight. In case 2 the mother said she was afraid a divorce would result if she defended the child from the father's hostility.

Therapy involved helping the mother to separate from her own mother and to express hostility toward her; simultaneously she was helped to accept hostility from the patient and to allow separation. As each mother became able to master some of her fears of separation, she was able to accept some of the father's hostility and to assume the role of wife rather than child, thus taking pressure off the child and allowing a positive father-child relationship to develop. The fathers have been difficult to involve and maintain in therapy. In cases 1 and 3 the fathers withdrew from therapy when parent-grandparent relations were touched upon; in case 2 the father was never involved.

REFERENCES

1. Guiora AZ: Dysorexia: a psychopathological study of anorexia nervosa and bulimia. Am J Psychiatry 124:391–393, 1967
2. Falstein EI, Feinstein SC, Judas I: Anorexia nervosa in the male child. Am J Orthopsychiatry 26:751–772, 1956
3. Bliss E, Branch CHH: Anorexia Nervosa. New York, Paul B Hoeber, 1960
4. Kaufman R, Heiman M: Evolution of Psychosomatic Concepts, Anorexia Nervosa, a Paradigm. New York, International Universities Press, 1964
5. Crisp AH: Clinical and therapeutic aspects of anorexia nervosa: 30 cases. J Psychosom Res 9:67–78, 1965
6. Crisp AH: Treatment regime for anorexia nervosa. Br J Psychiatry 112:505–512, 1965

Submission of New Research Abstracts for the 1974 Annual Meeting, May 6–10, Detroit, Michigan

THE 1974 ANNUAL MEETING, like the 1972 and 1973 meetings, will include a series of four New Research sessions. Those interested in presenting papers at these sessions should obtain an abstract from the Office of the Chairman of the Program Committee, American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009. It is not necessary to supply the full text of a paper submitted for consideration for New Research sessions. Completed abstracts must be received in the Office of the Chairman of the Program Committee by March 1, 1974.

LETTERS TO THE EDITOR

On "Maturational Lag"

SIR: Rather than reviewing the relatively large number of fundamental errors contained in Dr. Lloyd J. Thompson's "Learning Disabilities: An Overview" (April 1973 issue), I would prefer to indicate some of the more obvious ones, particularly ones that he lays at our door.

The term "maturational lag," to which he largely attributes reading disorders, is (like "temperament" and many other terms in our old usage) either tautological or meaningless. It is equivalent to the term "idiopathic": it may impress the layman but, at this time in our discipline, it is either a confession of ignorance of etiology or worse. Many "maturational lags" have been pinned down to their metabolic, traumatic, biologic, and socioeconomic causes. To add hypothetical genetic causation is not only to add confusion but possesses socially dangerous overtones when the author also adds that many families (as much as ten percent of the population) may be poverty stricken because dyslexia is familially aggregated and may be responsible for social failure.

The logic of this last issue fails badly when Dr. Thompson indicates that "several" men of great eminence (some of them named) had specific language difficulty. Further, he never makes it clear whether or not he considers dyslexia to be synonymous with reading retardation.

Dr. Thompson points to a study by Kawi and myself (1) in which we noted some causes of the same prenatal precursors of possible brain dysfunction that we found in a number of conditions where we also found overt neurological signs. He points with evident pride to an idea that he believes had not been perceived by others before, i.e., that "if one side of the brain is damaged . . . the other side takes over. . . ." He then immediately contradicts himself by referring to Lord Brain (2). Many workers have made similar observations. In our papers we have indicated repeatedly that the prenatal damage is largely anoxic, nutritional, or otherwise incurred so that the damage is diffuse and certainly bilateral (3, 4). It is true that one side may have suffered more severe insult, which would help explain one of the old findings to which Dr. Thompson refers, the theory of Samuel Orton's that reading disorders are due to "failure to establish unilateral brain superiority with definite dominance on one side" (5).

In another study we found that the same lack of dominance and being left-handed are also significantly associated statistically with the "continuum of reproductive casualty" previously mentioned. I might add that we have always maintained that the factors showing the greatest association by far with learning disabilities have been poverty and poor education rather than organic etiology; the latter is probably one of the more important findings in a middle- or upper-class private practice, where it is frequently labeled "maturational lag." We have also shown in other studies that it is people in these upper social strata who tend to compensate for their injuries, whereas those in the lower strata tend to go downhill (6).

As far as autism and hyperkinesis are concerned, we have found that they are also associated with brain-damaging precursors and with definite neurological signs of central nervous system impairment, among which hypokinesia, dyskinesias, aphasias, and numerous other signs, symptoms, and syndromes are present.

In sum, "maturational lag" is a result of a disturbance of central nervous system organization, the precise nature of which is sometimes known, sometimes unknown; it cannot be a *cause* of delay in maturation, whether that delay be generalized or restricted.

REFERENCES

1. Kawi AA, Pasamanick B: Association of factors of pregnancy with reading disorders of childhood. JAMA 166:1420–1423, 1968
2. Brain WR: Speech Disorders, 2nd ed. London, Butterworth, 1965
3. Pasamanick B, Knobloch H: Retrospective studies on the epidemiology of reproductive casualty: old and new. Merrill-Palmer Quarterly of Behavior and Development 12:7–26, 1966
4. Knobloch H, Pasamanick B: Prospective studies on the epidemiology of reproductive casualty: methods, findings and some implications. Merrill-Palmer Quarterly of Behavior and Development 12:27–43, 1966
5. Orton ST: Reading, Writing and Speech Problems in Children. New York, WW Norton, 1937
6. Knobloch H, Pasamanick B: Prediction from the assessment of neuromotor and intellectual status in infancy, in Psychopathology of Mental Development. Edited by Zubin J, Jervis G. New York, Grune & Stratton, 1967, pp 387–400

BENJAMIN PASAMANICK, M.D.
Albany, N.Y.

Dr. Thompson Replies

SIR: The remarks of Dr. Pasamanick concerning my article on learning disabilities have been read with interest and with appreciation. Some of the appreciation stems from the fact that Dr. Pasamanick's viewpoint is an excellent example of the interpretation that I was criticizing. In the article I stated that "others who recognize the condition hold that the cause must lie either in brain damage or in the way the child was reared or taught. The possibility of developmental lag is overlooked or rejected." Apparently Dr. Pasamanick belongs to this group.

It is also apparent that Dr. Pasamanick assumes that many positive findings in neurological and psychological examinations are evidence of brain damage, whereas they may come from developmental delays. Moreover, he states, "We have always maintained that the factors showing the greatest association by far with learning disabilities have been poverty and poor education rather than organic etiology." This statement places the cause of learning disabilities in environmental factors. In my article I quoted Macdonald Critchley, who said, "This syndrome of developmental dyslexia is of constitutional origin, and it is often—perhaps even always—genetically determined" (1, p. 18).

Dr. Pasamanick claims that the term "maturational lag" is

either "tautological or meaningless" and "equivalent to the term 'idiopathic.' " In the past two decades increasing attention has been given to developmental deviations that come not from brain damage or socioeconomic causes. In just over a decade many national and state laws pertaining to developmental disabilities have been passed; they are concerned with learning disabilities. Although the Orton Society, the first national organization to deal with specific language disability, came into being in 1949, the larger Association for Children with Learning Disabilities (ACLD) is barely ten years old. This shows the recent awakening of recognition of the problem and of the role played by maturational delays.

I wonder if Dr. Pasamanick would be so positive about causes of word deafness, tone deafness, dyscalculia, dyspraxia, color blindness, speech disorders, and the numerous other delays or lags in development. I wonder, too, how he accounts for gifts such as "photographic memory," "perfect pitch," "mathematical wizardry," excellent motor coordination, and unusual talent in other special fields. Are these gifts attributable to brain hyperplasia, affluence, or superior education?

Space does not permit more discussion of Dr. Pasamanick's claim of a "large number of fundamental errors" in my overview, but I believe time will tell some of the answers. A few short decades ago I was searching for and espousing the causes of these developmental disabilities in either brain damage or environmental influences, just as Dr. Pasamanick is doing, but I broadened my viewpoint.

REFERENCE

1. Critchley M: Developmental Dyslexia. London, William Heinemann Medical Books, 1964

LLOYD J. THOMPSON, M.D.
Chapel Hill, N.C.

Marijuana Flashbacks

SIR: I read Stanton and Bardoni's article "Drug Flashbacks: Reported Frequency in a Military Population" (December 1972 issue) with great interest. While it is important to note which drug the subjects *thought* caused their flashbacks, it is also important to realize that one drug may trigger a flashback relating to a previous experience with another drug (1, 2). Marijuana, for example, may trigger a flashback to a previous LSD experience.

In addition, I suspect that most, if not all, of their subjects who reported flashbacks used marijuana frequently.

REFERENCES

1. Ungerleider JT: Reply to JS Ketchum, Detection of LSD (Ltr to Ed). Am J Psychiatry 125:1448, 1969
2. Favazza A, Domino E: Recurrent LSD experience (flashbacks) triggered by marijuana. University of Michigan Medical Center Journal, Dec, 1969, pp 214–216

LT. CDR. ARMANDO R. FAVAZZA, MC, USNR
Oakland, Calif.

SIR: Seven varieties of drugs were associated with flashbacks by the questionnaire respondents in Stanton and Bardoni's article.

Amphetamines (speed), LSD, STP, and barbiturates are synthetic and are commonly available in a dosage form with standardized drug content. Morphine, opium, mescaline, and psilocybin are isolated from plant material and may be subject to some degree of refining error and lack of quality control. However, the vegetable product, marijuana, appears in this study to have had the least prospects for uniformity and control.

The tetrahydrocannabinol (THC) content of marijuana may vary from zero to eight percent; the THC content is determined by the drug's genetic variety, the manner in which it was processed, its age, and the conditions under which it was stored. The high significance of the THC content derives from the fact that it determines the amount of active substance administered, which in turn relates to the probability of induction of flashbacks.

The finding that the extremely potent hallucinogen LSD had a high incidence of flashbacks could probably also be demonstrated with tetrahydrocannabinol if the dosage were standardized and administered in an amount that induces a qualitatively similar hallucination. In this connection, the THC dose-response studies of Isbell and associates (1) may prove helpful.

In those questionnaire responses in which flashback was associated with a single drug, nine (11 percent) of the 81 individuals in Stanton and Bardoni's study attributed the effect to marijuana alone. Knowledge of the amount of THC consumed daily and of the duration of its use may affect our willingness to view such flashbacks as due to prepsychotic predispositions.

REFERENCE

1. Isbell H, Gorodetzsky CW, Jasinski D, et al: Effects of (-) -delta-9-trans-tetrahydrocannabinol in man. Psychopharmacologia (Berlin) 11:184–188, 1967

FLOYD E. ANDERSON, PH.D.
Alexandria, Va.

Dr. Stanton Replies

SIR: Data that we have recently collected (1) support Dr. Favazza's contention that a relationship exists between extent of marijuana use and susceptibility to "acid" flashbacks. We also point out, however, the applicability of a different interpretation, i.e., that acid flashbacks may lead to greater marijuana use (rather than that increased marijuana use leads to acid flashbacks).

Dr. Favazza documents the idea that marijuana induces LSD flashbacks by referring to an earlier case study he undertook with Dr. Edward Domino. In my opinion there is more evidence that the patient in this study shows a borderline or prepsychotic adjustment than is attested to by the authors. In particular, the MMPI data for their patient showed a fairly severe level of maladjustment and I would be interested in seeing the total computerized MMPI report obtained. It is unfortunate that no MMPI was administered to this patient at an earlier date, which would have provided us with a baseline. As in the case mentioned in our most recent study (1), I wonder whether the prime variable is not ego functioning rather than marijuana per se.

Dr. Anderson appears to assume that higher dosages of LSD would be more likely to induce flashbacks and that the same would hold for marijuana flashbacks. Concerning the former drug, however, Smart and Bateman (2) claimed that higher dosages do not produce more extreme psychotomimetic effects, although more frequent usage does induce flashbacks.

Our recent data (1) do not support this second claim, nor do they indicate that such a process occurs with marijuana. Unfor-

tunately, we do not have single-dosage data on our subjects for either acid or marijuana and must predicate our conclusions on frequency-of-use data. Nonetheless, I am not yet convinced that there is such a thing as a marijuana flashback, or at least that such a flashback has as strong a pharmacological basis as LSD flashbacks. So often the claimed marijuana flashback can be attributed to déjà vu, hallucinatory phenomena, previous use of a more potent hallucinogen, expectancy and social setting (3, 4), etc. I would have to say that while it is worth further pursuit, Dr. Anderson's notion is unproven and contrary to much of the evidence.

REFERENCES

1. Stanton MD, Mintz J, Franklin RM: Drug flashbacks II: some additional findings (submitted for publication)
2. Smart RG, Bateman K: Unfavourable reactions to LSD: a review and analysis of the available case reports. Can Med Assoc J 97:1214–1221, 1967
3. Carlin AS, Bakker CB, Halpern L, et al: Social facilitation of marijuana intoxication: impact of social set and pharmacological activity. J Abnorm Psychol 80:132–140, 1972
4. Keeler MH, Reifler CB, Liptzin MB: Spontaneous recurrence of marijuana effect. Am J Psychiatry 125:384–386, 1968

M. DUNCAN STANTON, PH.D.
Philadelphia, Pa.

Confusion About Schizophrenia

SIR: A major problem exists in the area of psychiatry today, one that confuses all of us involved in this area of endeavor. That problem is the present classification of schizophrenia in the *Diagnostic and Statistical Manual of Mental Disorders*, second edition (*DSM-II*) (1). This classification is actually three mutually exclusive subclassifications; each subclassification can incorporate diagnostic criteria shared by the other two.

The first subclassification is based on Eugen Bleuler's description of symptoms, which supposedly qualitatively differentiates schizophrenia from other psychiatric disorders. Subclassification I, the Bleuler subtype, inlcudes 1) paranoid schizophrenia, 2) hebephrenic schizophrenia, 3) catatonic schizophrenia, and 4) simple schizophrenia.

The second subclassification is based on Langfeldt's ideas and differentiates schizophrenia from other entities using prognosis as the differentiating feature rather than symptomatology. This classification in no way relates to the previous Bleuler subtypes. Subclassification II, Langfeldt's concepts, includes 1) acute schizophrenic reaction, or reactive schizophrenia; 2) chronic undifferentiated schizophrenia, or process schizophrenia; 3) ambulatory schizophrenia, or residual schizophrenia; and 4) latent schizophrenia.

The third subclassification uses qualitatively differentiating symptom complexes or syndromes that are completely different from the symptom complexes identified in subclassification I. Subclassification III comprises 1) schizo-affective schizophrenia and 2) schizophrenia, other, e.g., pseudoneurotic schizophrenia.

Let us take the case of one hypothetical patient to demonstrate some difficulties with this classification. A 26-year-old man has had possible delusions, loose associations, and somewhat manic affect for some weeks. Where does he fit? Is he a paranoid schizophrenic or, since his affect is altered, is he a schizo-affective schizophrenic or, since his illness has been going on for some time, is he a chronic undifferentiated schizophrenic? Actually, a few weeks is not really a terribly long time, and since our classification does not specify a given time period perhaps he represents an acute schizophrenic reaction in a latent or ambulatory schizophrenic.

Some people would use one category, others another, to classify this illness. There is no doubt in my mind that one reason people throw up their hands in despair and are so confused about the nature of schizophrenia is this impossible classification. It seems to me that one way to clear up some of this confusion would be to reclassify schizophrenia and, going even one step beyond, to hold an international conference at which workers in the field of schizophrenia can establish some international standards that would be accepted by all. Should these steps be taken then perhaps when one investigator discusses schizophrenia another investigator will know exactly what he or she is talking about. But this can be the subject of another letter.

REFERENCE

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. Washington, DC, APA, 1968

ALVIN S. YUSIN, M.D.
Los Angeles, Calif.

Effects of Nutrition on Schizophrenia

SIR: "Relapsed Schizophrenics: Earlier Discharge from the Hospital After Cereal-Free, Milk-Free Diet" by Drs. Dohan and Grasberger (June 1973 issue) is a highly interesting paper. I would like, however, to question the authors' interpretation of the results.

All of the patients in the study were receiving phenothiazines. It could be that milk or cereal extracts contain certain substances that are competitive inhibitors, or in other ways interfere with the pharmacological action of phenothiazines.

I wonder if a gluten-free diet would help patients not treated with phenothiazines, or if increasing the dosage of phenothiazines would help the group whose recovery was slowed by glutens. Also, because of a pet interest of mine, I wonder what the nicotinamide intake levels were for the patients in both groups.

Clinical research is an exceedingly complex and hazardous path, and I salute the courage of those who choose it, with all its variables and pitfalls.

GORDON A. BAKER, M.D.
Toronto, Ont., Canada

Dr. Dohan Replies

SIR: Dr. Baker suggests that the beneficial effect for relapsed schizophrenics of a diet free of cereal grains and milk could be due to the absence of inhibitors of phenothiazines. I consider this a thoughtful suggestion but an unlikely explanation for the following reasons:

1. In an intra-individual comparison of the length of stay in a locked ward of 20 schizophrenics who were admitted to the ward twice within 91 days and who were assigned at random to the high-cereal diet at one time and to the cereal-free diet another, we found that the cereal-free episode was shorter in 16 of the 20 paired episodes ($p = .006$). Three patients did not receive antischizophrenic medication during the cereal-free episode but

did receive it during the high-cereal episode. The cereal-free episode was shorter in all three patients.

2. In unpublished preliminary tests conducted in 1964 three unmedicated relapsed schizophrenics showed definite improvement on a gluten-free, milk-free diet within a few weeks but became worse or failed to continue to improve if they ate wheat products. I now believe, however, that all cereal grains should be omitted from tests of the effects of diet because schizophrenia occurs (possibly with less frequency) in societies that eat primarily other grains than those omitted in the usual gluten-free diet, i.e., wheat, rye, barley, and, sometimes, oats (1).

3. Prof. G.K. Anastasopoulos of Thessaloniki observed marked improvement in schizophrenics and paranoiac patients when Greece faced a starvation period during the Nazi occupation in World War II: "Bread, a basic food for Greeks, was for many months something quite nonexisting" (2).

4. Investigators of celiac disease, which I suspect probably has one or more genes in common with genotypes for schizophrenia, have noted that large doses of gluten or its subfractions frequently produce severe emotional disturbances, including psychotic behavior, in celiacs (3). Also, the psychological symptoms of celiacs are usually the first to improve on a gluten-free diet.

In addition, there is evidence indicating that restriction of cereal grain has a preventive effect on the occurrence of schizophrenia. The changes (+15 percent to −45 percent) from prewar values in first admissions for schizophrenia during World War II in five "Western" countries were highly correlated ($r = .96$; $p < .01$) with marked changes in wheat and rye consumption and were unrelated to war status; availability of beds, doctors, alcohol, and employment; or to admissions of other psychoses. In Shanghai, Kurt Wolff (4) noted a decrease of 20 to 25 percent in the number of schizophrenics and an increase of some other disorders in his psychiatric practice during the shortages of rice and bread in World War II.

Dr. Baker also asks about the relative nicotinamide intake of the two groups in the study described in the *Journal*. The amount per 1,000 calories of nicotinamide's precursor, niacin, in the cereal-free diet was slightly less than that in the high-cereal diet. Patients on both diets were given one hexavitamin capsule that contained 20 mg. of nicotinamide per day.

REFERENCES

1. Dohan FC: Cereals and schizophrenia: data and hypothesis. Acta Psychiatr Scand 42:125–152, 1966
2. Anastasopoulos GK: Personal communication, March 8, 1969
3. Dohan FC: Celiac disease and schizophrenia. Lancet 1:897–898, 1970
4. Wolff K: Personal communication, April 9, 1970

F.C. DOHAN, M.D.
Philadelphia, Pa.

Tardive Dyskinesia and Low Dosage

SIR: The medical and psychiatric literature regarding the subject of tardive dyskinesia is rapidly accumulating and cautions are advised regarding the need for the appropriate use of antipsychotic drugs. A recent *FDA Drug Bulletin* (1) addressed itself to the subject and, in keeping with the majority of reports, emphasized the enhanced risk with high dosages and long durations of drug therapy.

Indeed, the risk may be greater. We have recently reported two cases of tardive dyskinesia, one of which was quite severe, that occurred after the administration of low dosages of chlorpromazine and fluphenazine (2). One case involved the administration of 50 mg. of chlorpromazine at bedtime as a hypnotic for approximately two and a half years. The other involved the administration of 7.5 mg. of fluphenazine daily for two years. Recently Simpson reported three case of tardive dyskinesia occurring with low dosages (3); one of these involved the administration of 10 mg. of trifluoperazine daily for less than one year.

This represents only a small number of instances in which tardive dyskinesia occurred after the administration of small doses of phenothiazines. It appears to us that these cases call for even more explicit caution in the use of these drugs. Continuing their use in patients for other than antipsychotic purposes is inappropriate at this time. The recent marketing of promethazine (Rem-sed) as a hypnotic would represent an example of potentially hazardous and inappropriate use of a phenothiazine.

REFERENCES

1. Tardive dyskinesia associated with antipsychotic drugs. FDA Drug Bulletin, May 1973
2. Thornton WE, Thornton BP: Tardive dyskinesia from the major tranquilizers. J Florida Med Assoc 60:24–26, 1973
3. Simpson GM: Tardive dyskinesia (Letter to the Editor). Br J Psychiatry 122:618, 1973

WILLIAM E. THORNTON, M.D.
BONNIE PRAY THORNTON, R.N.
Naples, Fla.

Empty Hospital Beds and Human Misery

SIR: High praise is due to Dr. Robert Reich for his Editorial "Care of the Chronically Mentally Ill—A National Disgrace" (August 1973 issue). Dr. Reich tells us what happens to the chronically ill who are discharged prematurely, who wander the streets or who waste away in unsupervised nursing homes. The current trend to treat *all* mentally ill persons in the community is moving relentlessly like a juggernaut. The statisticians and politicians can point to empty hospital beds but the result will be a grim and tragic joke in human misery.

Dr. Reich not only criticizes but he points to a realistic, humane, but expensive solution. Copies of this Editorial should be reprinted and supplied to the governors, mental health commissioners, legislators, and state hospital superintendents of every state in the Union. My congratulations to Dr. Reich for telling it like it is.

ZIGMOND M. LEBENSOHN, M.D.
Washington, D.C.

SIR: The Editorial by Robert Reich, M.D., was like music to my ears. My wife stated that it should be printed indelibly on the hearts and minds of the professional perpetrators of these plans. However, I reminded her that those anatomical parts are frequently missing from such people. This belief of mine was further amplified by the chief perpetrator of this sort of plan in the Commonwealth of Pennsylvania when he prefaced one of his speeches with the following statement: "I don't know what the hell I'm doing but I'm having a lot of fun doing it." This was not only the preamble but the total text of his speech.

At the present time, the system in Pennsylvania is forcing chronically institutionalized people back into the community to live on $110 a month. These people have never before cooked

for themselves, purchased food, washed their clothes, or learned about mugging. They are placed in a ghetto where it is not safe to step outside the door and where their checks may be stolen. If four or five are moving to the same address, they may have a social worker live with them for a week in order to span the gulf between the many years of institutional living and present-day community life. A day or two after the social worker leaves, the first patient is going to need to be admitted to an $85-a-day private psychiatric unit, where the laborious two- to three-week process of recommiting him is undertaken.

Meanwhile, back at the hospital, where there had been peace and tranquillity for these people, the remaining patients are all being put into a few buildings so that they appear to be crowded and daily costs of institutional care can be shown statistically to be rising astronomically.

The interesting thing is that this big, ugly mess is going to be sold to the people in the next political campaign as positive evidence of humanitarianism and money saving on the part of politicians. My sentiments were published in a letter to the editor of the Pennsylvania Medical Journal (1) but they were not stated so beautifully as in the Editorial by Dr. Reich. I do hope that there will be more response than just mine to this serious matter and that Dr. Reich will continue to write in the same vein so that in this century we might start throwing rocks at the right people.

REFERENCE

1. Blank JE: Questions move to community care (Letter to the Editor). Pa Med 76:33, 1973

JOHN E. BLANK, M.D.
Sharon, Pa.

Biochemical Aspects of Sensitivity Reactions

SIR: It was interesting to read about the curious side effect of imipramine used for treatment of hyperkinetic children reported by W.S. Ryback, Philip A. Jorgensen, and Shirley E. Jorgensen in their Letter to the Editor "Sensitivity Reaction to Imipramine" (August 1973 issue).

I have observed a very similar syndrome of a child becoming tearful and hypersensitive during administration of dextroamphetamine for the treatment of hyperkinesis. This occurred primarily with children who were given little affection at home and/or were exposed to aggression by the parents.

Considering the biochemical aspects of these drugs, both dextroamphetamine and imipramine increase the concentration of biogenic amines in the brain. The paradoxical response of some children to these two drugs certainly merits further investigation.

MINOO P. CHINOY, M.D.
Los Angeles, Calif.

Surgery Using Hypnosis in 1845

SIR: William S. Kroger's reference to hypnosis and breast surgery in "Acupunctural Analgesia: Its Explanation by Conditioning Theory, Autogenic Training, and Hypnosis" (August 1973 issue) reminds me of an article I found most interesting. The first volume of the *Southern Medical and Surgical Journal*, published in 1845, contained a paper titled "Extirpation of the Mamma of a Female in the Mesmeric Sleep, Without Any Evidence of Sensibility During the Operation" by L.A. Dugas, M.D., Professor of Physiology, Medical College of Georgia.

The article states that on January 3, 1845, Dr. Dugas and a Mr. B.F. Kendrick induced a trance in a 47-year-old white married woman who was suspected of having cancer of the breast. They worked with her for ten days and then on January 12 performed a radical mastectomy using no anesthetic other than hypnosis. She was awake during the entire procedure and did well until she had a recurrence of the cancer and a second operation was performed under hypnosis on November 19, 1845. This second operation was described in volume two of the *Southern Medical and Surgical Journal*. The woman finally succumbed to metastasis but suffered no ill effects from the surgery or the hypnosis.

I am not sure whether this is the first recorded mastectomy under hypnosis but it is surely one of the earliest. These early volumes of the *Southern Medical and Surgical Journal* are in the archives of the medical library of the Medical College of Georgia at Atlanta.

M.B. SELL, M.D.
Augusta, Ga.

Educating the Scientist-Physician

SIR: I read with great interest Dr. Louis Jolyon West's erudite and comprehensive vision of "The Future of Psychiatric Education" (May 1973 issue). I am in full agreement with Dr. West's propositions that psychiatric education should be characterized by "its responsiveness to the great surge of science" and that psychiatry should become "more and more firmly identified with the profession of medicine." At the same time, I fervently hope that psychiatry will continue to attract and be enriched by scientist-physicians who, in the eloquent words of William Faulkner:

> shall have the power and the will to choose right from wrong . . . who will refuse always to be tricked or frightened or bribed into surrendering, not just the right but the duty, too, to choose between justice and injustice, courage and cowardice, sacrifice and greed, pity and self . . . who will believe always not only in the right of man to be free of injustice and rapacity and deception, but the duty and responsibility of a man to see that justice and truth and pity and compassion are done (1, p. 123).

REFERENCE

1. Faulkner W: Address to the graduating class, University High School, in Essays, Speeches, and Public Letters. Edited by Meriwether JB. New York, Random House, 1965, pp 122–124

STEVEN LIPPER, M.D., PH.D.
Chapel Hill, N.C.

Basic Research and Suicide Prevention

SIR: Suicide continues to be a major problem in the United States. Some 20,000 people kill themselves each year and it is estimated that there are some 2,000,000 people in America who have attempted suicide (1). During the last decade, a large effort was launched to deal with this problem. During the 1960s,

over 200 suicide prevention centers were established in communities throughout the country. In 1966, the National Institute of Mental Health formed a Center for Studies of Suicide Prevention. In 1967, that center started the *Bulletin of Suicidology* in order to stimulate interest and concern in the topic. In 1968, the American Association of Suicidology was formed.

The net result of all this effort and expense has been that the problem of suicide in America continues unchanged. We have not prevented suicide (2). The suicide rate in America—even in communities with suicide prevention centers—has not decreased. The people who call suicide prevention centers are not in general those who commit suicide. The typical caller to a suicide prevention center is a middle-aged woman with interpersonal problems, while the typical suicide is an isolated elderly man.

A recent review of attempts to predict who will kill themselves indicated that the number of false positives with such predictive scales (that is, the number of nonsuicidal people who are classified by the predictive scales as potential suicides) is so large as to render the scales useless (3).

Although suicide prevention centers provide useful community mental health services for their catchment areas, they have not prevented suicide. Why? The answer would seem to lie in our lack of understanding of the psychodynamics of suicidal behavior. We cannot prevent suicide because we do not know what causes people to kill themselves. We can occasionally pinpoint particular antecedent events or concomitant personality traits, but suicide is a relatively rare event: most people with these antecedents or concomitants do not kill themselves (4).

The suicide prevention movement has illustrated a basic point that is often stressed but continually ignored: that basic knowledge and sound research to unearth that knowledge are critically important. We cannot expect to apply knowledge usefully until we have accumulated enough knowledge as a base. The suicide prevention movement generated a good deal of enthusiasm and fanfare, but because there was (and still is) a lack of fundamental knowledge about suicidal behavior, the enthusiasm waned and the trumpets were put away without any achievements to herald.

The Center for Studies of Suicide Prevention at NIMH was disbanded last year. Yet in 1973, as in 1966, about 20,000 people will kill themselves in America.

REFERENCES

1. Dublin LI: Suicide: A Sociological and Statistical Study. New York, Ronald Press, 1963
2. Lester D: The myth of suicide prevention. Compr Psychiatry 13:555–560, 1972
3. Lester D: Attempts to predict suicidal risk using psychological tests. Psychol Bull 74:1–17, 1970
4. Lester D: Why People Kill Themselves: A Summary of Research Findings on Suicidal Behavior. Springfield, Ill, Charles C Thomas, 1972

DAVID LESTER, PH.D.
Pomona, N.J.

Prevalent Sexual Misconceptions

SIR: Oversimplifications are always regrettable, and in no sphere are these errors more unfortunate than in the area of some commonly held ideas concerning the sexual drives. Without attempting anything like a bill of particulars, I would like to mention several beliefs that I believe need clarification:

1. *Frigidity.* As such, frigidity is nonexistent. Sexual apathy, going sometimes to the point of revulsion, is occasionally seen but it is frigidity toward a particular sexual target. The same man or woman can feel and demonstrate great ardor and potency toward certain people who happen to attract them—be they men to women, men to men, or women to women. Frigidity, therefore, is selective and can be chronic or sporadic.

2. *Nymphomania and satyrisis.* These syndromes do occasionally exist in pure cultures; the desire for orgasm—be it complete, partial, physiological, or, tragically, psychologically caused—is apparently insatiable. These people are sick. The ancient saying regarding Don Juans, Casanovas, Sapphos, and courtesans applies: "A thousand men [or women] are not enough, but one man [or woman] is too much."

3. *Impotence.* If, particularly in men, impotence is anatomically and physiologically determined, erection is impossible. However, if these conditions do not prevail, impotence in both sexes is psychological; thus it is like frigidity and is theoretically and often actually amenable to amelioration, with the end result of potency.

MARK LEWIS GERSTLE, M.D.
San Francisco, Calif.

Measuring Responses During Treatment

SIR: I would like to comment on the article "The Polygraph in a Psychiatric Setting" by Stanley Abrams, Ph.D. (January 1973 issue). Measurements of physiological responses have been made many times in the past in a "stimulus-response" setting, which is similar to that used by Dr. Abrams. What is needed ideally, however, is measurement of these responses during ongoing treatment sessions over the entire length of the treatment hour. Such measurement would, again ideally, involve the use of remote sensors rather than contact sensors and would measure more than a few psychosomatic and physiological responses.

As the treatment hour progressed, a pattern for each measured variable would emerge that could be correlated with the content of the session. To give a simple example, heart rate might increase during periods of anxiety. Furthermore, the patterns of all the variables measured could be correlated with each other by means of a computer.

The computer can sift at very rapid speeds a vast number of appropriate responses programmed into the computer gradually as research indicates what the changes in the variables signify concerning the differing affective states of the patient. The most appropriate response for any given patient at any given moment could then be chosen.

Computers capable of managing multivariable data are available in size and cost compatible with office psychiatric use. Computers that will respond vocally are also available, but there are none yet that can understand verbal content. This is one reason why we need psychobiological sensors. Another need is for validation of the patient's subjective interpretation of the causes of affective changes.

Psychiatry as it is known today will change markedly in the relatively near future; it will stand on scientific ground. The role of the psychiatrist will also change markedly; the very question of the need of the interpersonal therapist may have to be radically reexamined.

HARVEY A. LEWIS, M.D.
Baltimore, Md.

BOOK REVIEWS

Comprehensive Group Psychotherapy, *edited by Harold I. Kaplan, M.D., and Benjamin J. Sadock, M.D. Baltimore, Williams & Wilkins Co., 1971, 871 pp., $27.50.*

Group psychotherapy, which is one of the most rapidly expanding treatment modalities within the mental health field, has urgently needed a basic definitive textbook that would present in a lucid, unbiased, and eclectic manner the nature of this complex field for the psychiatrist. In *Comprehensive Group Psychotherapy*, Drs. Harold I. Kaplan and Benjamin J. Sadock have admirably fulfilled this calling. They have presented American psychiatry with the "book of record" of group therapy—long needed, beautifully written, printed, and illustrated—in short, outstanding.

The organization and orientation of this book is to foster professional competence and to provide a comprehensive survey of the therapeutic techniques that dominate contemporary group practice. The text is organized into four major areas. The first, on basic principles, covers the evolution of group therapy with a well-written historical survey by E. James Anthony. New material on Freud's interest in groups is provided for the first time in an interesting chapter by Mark Kanzer. An excellent overview of the many types of group therapy available—their differences and similarities—is provided in a chapter by Hyman Spotnitz. In addition, the editors have written a chapter on the role of clinical diagnosis in group therapy, confirming and emphasizing the importance of proper selection of patients and organization of the group.

The second area, dealing with specialized group therapy techniques, provides a description of the classical and new methods, many described by their originators. Alexander Wolf and Emanuel Schwartz describe their technique of group psychoanalysis; Jacob Moreno writes on psychodrama, the method he conceived; and Joseph Wolpe contributes his expertise on the use of behavior therapy in groups. Murray Bowen has a very thorough chapter on family therapy and the newer method of family group therapy. Louis Gottschalk describes the new groups—encounter, sensitivity, T-groups, marathons—with superb objectivity, outlining both their assets and liabilities and including an extensive review of psychiatric casualties. John Dusay and Claude Steiner (both students of the late Eric Berne) write with authority on transactional analysis from a theoretical and practical point of view. Also, the editors describe their particular technique of structured interactional group psychotherapy, which combines psychoanalysis and operant conditioning and holds much promise for the future.

This section also includes a special chapter on psychopharmacology as it relates to group therapy written by two of the leading figures in the field, Nathan Kline and John Davis. Their chapter presents the basic core of information on drugs including dosages, indications, contraindications, and side effects. It gives practical hints on drug therapy and deals with the importance of having accurate knowledge of psychopharmacology in order to provide for reality testing in the therapeutic situation. In many ways this unique chapter can stand as a book by itself.

The third area of the text deals with groups in special categories; as the editors note in their introduction to this section, the group method of treatment has been and continues to be applied to a widening range of patients with highly diverse problems. Accordingly, we find a fine chapter on the group treatment of homosexuals by Toby Bieber, which includes a theoretical review of the causes of homosexuality. Other patient populations such as children, adolescents, the psychosomatically ill, alcoholics, neurotics and psychotics, and the old and aged are included. A most timely chapter by Joyce Lowinson and Israel Zwerling deals with the treatment of the narcotic addict and discusses group methods, methadone maintenance, and the use of therapeutic communities such as Synanon and Odyssey House.

The fourth area of the book, on training and research, contains a chapter by Martin Grotjahn titled "The Qualities of the Group Therapist" that should be read by all persons who practice psychotherapy, individual or group. He writes that the psychotherapist must be a man for all seasons—reliable, inviting trust and confidence, and prepared for a lifetime of learning. It is a remarkable essay that is full of wisdom, honesty, and sincerity. Finally, the editors contribute a chapter in this section that outlines a major concern facing the group therapy field today—the training of competent group leaders and the setting of standards of practice. In an effort to protect both the patient and the practitioner, they suggest solutions to these problems that are innovative, reasonable, and appropriate. The book concludes with a complete and accurate glossary of psychiatric and group psychotherapeutic terms.

Is this book justifiably called "comprehensive"? I believe so, for it includes the leading theoreticians and practitioners of group therapy, who present their views in a uniquely balanced, well-organized, and detailed clinical manner.

Drs. Kaplan and Sadock, joined by Alfred M. Freedman, are apparently becoming the encyclopedists of modern psychiatry, presenting an academic restructuring of modern-day psychiatric education. From the *Comprehensive Textbook of Psychiatry* (1), through the *Modern Synopsis of Comprehensive Textbook of Psychiatry* (2), they are presenting a new and refreshing approach to psychiatric educational writing. *Comprehensive Group Psychotherapy* is in this tradition. It is a proud accomplishment to be included as part of the basic library of every specialist in human behavior. There simply is no book like this available in the literature.

REFERENCES

1. Freedman AM, Kaplan HI (eds): Comprehensive Textbook of Psychiatry. Baltimore, Williams & Wilkins Co, 1967
2. Freedman AM, Kaplan HI, Sadock BJ: Modern Synopsis of Comprehensive Textbook of Psychiatry. Baltimore, Williams & Wilkins Co, 1972

HENRY I. SPITZ, M.D.
New York, N.Y.

The De-Addiction Process, *by Leon Brill. Springfield, Ill., Charles C Thomas, 1972, 162 pp., $9.50.*

There is an old wives' tale that says, "Once an addict, always an addict." Many people still believe this nonsense, including some who ought to know better. Leon Brill has written a book about the process by which heroin addicts recover, but unfortunately it will not convince skeptics and pessimists who believe that heroin addiction is incurable. The book will not convince them, for it is more a case book than a well-reasoned scientific monograph. But Brill tells us about real people, not about the fantasies of old wives.

This book is the story of eight addicts' lives, which were chosen to illustrate paths into and out of addiction. The book has little scientific methodology and an indifferent discussion of the relevant literature; the editing is casual to sloppy. The veracity of each case report is limited by retrospective data collection. Nevertheless, Brill's book offers us the best case histories available.

You see, in the field of addiction, Brill is a rarity. He is a professional who has worked directly with addicts for more than 20 years. On the one hand, so many of the so-called authorities in the field of addiction have been people who have dined out on their ability to write about and often to grind axes upon the subject of drug addiction. On the other hand, they have been administrators who have quickly and with limited clinical experience risen to prominence in fashionable treatment programs only to lose interest as fashions or their own professional focus changed. For many writers, addiction has offered a colorful Rorschach blot to be endlessly distorted by the writers' own personal or political projections. But like Marie Nyswander and Harris Isbell, Leon Brill has devoted his life to the care and study of addicts. He is one of the few really experienced professionals in the field.

Leon Brill reports the lives of eight addicts as they experiment with drugs, adapt to drugs, become physiologically addicted to drugs, and then build tolerance for this life. He then describes how, with time, these same heroin addicts develop tolerance for and finally adapt to abstinence. As Brill says, "The major aspect of this process is that it evolves slowly with a great deal of learning and adaptation required in each phase and numerous decisions to be made along the way." Often experiences and decisions critical to abstinence occurred months and years before stable abstinence was achieved. Brill points out that substitutes for addiction are necessary for its cure, and most often these substitutes are new gratifying relationships with people or dependence upon humane institutions. Methadone helps but is not necessary; and although Brill does not emphasize it, compulsory supervision seemed to help some of his subjects.

Without moralizing, psychologizing, muckraking, or romanticizing, Brill has chronicled the tempo, excitement, and pain of each addict's life. He has deliberately reported the case histories with a minimum of editing. But because his case histories are thorough, the reader can pick out for himself the defensiveness and distortions that the addicts and their observers have introduced.

James Mills in *Panic in Needle Park* (1) and Claude Brown in *Manchild in the Promised Land* (2) captured some of the same authenticity, but Brown and Mills lacked Brill's experience. It is a pleasure to read a book written by someone who seems to have paid attention to what the lives of addicts are really like. Sophisticated readers will be bothered by the book's lack of literary and scientific craft and by its lack of novelty. However, I recommend *The De-Addiction Process* to every graduate student, social worker, physician, and probation officer who wishes to understand the natural history of heroin addiction and in doing so to gain empathy with addicts as human beings.

REFERENCES

1. Mills J: Panic in Needle Park. New York, Farrar, Straus & Giroux, 1966
2. Brown C: Manchild in the Promised Land. New York, Macmillan Co, 1965

GEORGE E. VAILLANT, M.D.
Cambridge, Mass.

The Hyperactive Child: A Handbook for Parents, *by Paul H. Wender, M.D. New York, Crown Publishers, 1973, 114 pp., $3.95.*

Medical books for patients are unusual reading for most physicians, yet we often become aware of the author's message from the kinds of approaches and questions brought to us by patients. This book faces two formidable tasks. The first is that of writing in lay terms about a confusing medical subject; the second is trying to advise parents who are harassed by a prickly disorder in their child that threatens to disrupt many family patterns. Dr. Wender takes a firm approach to these tasks. After defining the many forms of hyperactivity and putting the disorders into a developmental context, he makes the point that he must frequently use the terms "some," "many," and "most" rather than "always," "every," or "never."

Indeed, he makes incessant use of the former terms. "Some" becomes the chief word for describing the excessive activity, attention difficulties, impulsivity, learning difficulties, and all of the temperamental problems of hyperactive children. "Most" includes the author's concept that the syndrome is essentially genetic. Because of this he feels most comfortable in deriding psychiatrists, especially child psychiatrists, who stick to a purely environmental cause. He reiterates, from his scientific writings, concepts regarding the dysfunction of the brain as opposed to damage to it, and he restates his feeling that medication is the prime therapy for all of these children.

This finally leads him to a very intriguing chapter titled "Finding Help for the Hyperactive Child." It is a frank set of guidelines for parental moves toward finding a physician without annoying the latter. Some of his clues about going to a university setting will be liked by a few but disliked by many practicing physicians. In addition, his description of the "flexible" psychiatrist will be looked on as a literary gem or an ivory-tower horror.

The book should be of considerable assistance to many parents, should stir up those professionals who feel that Wender's theoretical position is incorrect, and should both annoy and relieve many competent physicians.

HENRY H. WORK, M.D.
Washington, D.C.

The Savage God: A Study of Suicide, *by A. Alvarez. New York, Random House, 1972, 294 pp., $7.95.*

This book on suicide starts with an account of the completed suicide of a poetess who was a close friend of the author and ends with a recounting of the author's attempted suicide. In between, its few chapters vary from superb to good and range in

style from intensely personal to encyclopedic-historical. I found the first chapter ostentatiously belletristic, perhaps turning off readers who may well be intrigued with the subsequent chapters. But because of the theme of the book, it perhaps had to be organized this way.

The author has done a fair amount of historical research, but this is available in more detail elsewhere. He does best when he examines the influence of suicide on a large number of authors and includes a few other types of artists as well. His disenchantment with the mystique or romance of suicide, based on his own abortive attempt, leaves one with the question: If not alcohol, suicide, or divorce, what then? Constructive alternatives are not considered.

To a psychiatrist it is curious that the author can ignore the overriding importance of affective disorder in the writers surveyed. Alvarez relates many instances of unusual productivity, irritability, and insomnia preceding the intellectual sterility of black depression at the time of suicide. And although half of all suicides are associated with abuse of alcohol or drugs, he omits consideration of alchoholism, although his own attempt at suicide was made when he had been drinking. The role of depression in schizophrenia is also ignored. It is true that suicide is not a disease, but on the other hand, certain disease conditions do make suicide hypnotically attractive as a problem-solving maneuver.

I think it unfortunate that this book may be the first and only book on suicide that many readers will see. Yet because of its provocative nature, it is worthwhile for persons interested in self-destructive behaviors.

PAUL H. BLACHLY, M.D.
Portland, Ore.

Psychotherapy: 1971, *edited by Joseph D. Matarazzo, Allen E. Bergin, Jerome D. Frank, Peter J. Lang, Isaac M. Marks, and Hans H. Strupp. Chicago, Aldine-Atherton, 1972, 579 pp., $20.*

This is the first volume of what will be an annual series. It contains a collection of articles on psychotherapy that were published in 1971. The editors feel that these papers are the most significant ones on the subject published during that year. There is a total of 48 articles; the subjects vary all the way from research on psychoanalysis through the psychodiagnosis of the Negro slave to the electrical toilet training of institutionalized adult retardates. Fortunately, each article is briefly previewed in the introduction and most are summarized under the chapter headings so that the reader can easily pick out for himself which particular facet of psychotherapy he wishes to explore at length.

The emphasis in selection is on behavior therapy; 19 of the papers deal with some aspect of this mode of treatment. Those on insight therapy dwell on the difficulties encountered in evaluating its effectiveness. They stress the "proven" value of empathy over interpretation as a useful therapeutic tool. There is considerable repetition in the articles that deal with this subject, and one wonders if recent work on hypnotherapy and more than one short article on family therapy might not have warranted inclusion rather than some of those papers which simply show that accurate evaluation of the usefulness of psychotherapy is impossible to accomplish.

Most of the papers report on careful work done by well-qualified researchers, and two are enlivened by the considerable emotional involvement of the author. One, *"The Sane Slave"* by Thomas Szasz, compares an 1851 paper on psychiatric illnesses peculiar to slaves with present racist attitudes that the author perceives in some modern therapists. The other, by Sigmund Koch, is an empassioned diatribe against encounter group therapy and the reputed value of "stripping down" the personality. Both make for exciting reading.

Anyone looking for information about the present status of the art of psychotherapy will find it here. Almost all forms of behavioral therapy are clearly described, and current efforts at research in the more traditional modalities are thoroughly covered.

GRAHAM B. BLAINE, JR., M.D.
Stockbridge, Mass.

Halfway Through the Tunnel, *by Barry R. Berkey, M.D. New York, Philosophical Library, 1972, 215 pp., $7.50.*

Dr. Berkey's heroine in this fictionalized monologue (à la Portnoy, she does all the talking) is allegedly intelligent, verbal, overweight, angry, depressed, inhibited, and now in treatment with her fifth psychiatrist. The therapist's verbal and nonverbal contributions are evident only as reflected by the patient, who is in concurrent individual and group treatment. Each chapter covers one of the individual sessions.

On the first reading this appears to be just another exposé of the secret goings-on in a psychiatrist's sanctum. However, more careful study demonstrates the masterful job the author has done in presenting the essence of the verbalizations of this type of patient as she struggles from one existential crisis to another. The smooth flow of tragedies, large and small, is occasionally interrupted by the author's efforts to make some psychodynamic mechanism obvious; lay readers seeking titillation will find more doggy do than sex in these pages. But any reader sooner or later will ask, "What *could* this lady be thinking that she talks this way?" It appears rather obvious that this patient, like so many others, constructs semantic invalidities faster than Mr. Carter used to make pills.

Considering only the apparent factors, it may not be inappropriate to hope for a better way to teach a patient that perceptions should not be trusted, that anger is dangerous, and that depression can be lethal. Or must kairos, the crucial moment, forever remain operationally undefinable in psychiatry?

A brief glossary explains the patient's idiosyncratic vocabulary plus a few psychiatric terms; the author defines the latter with simple words like "emotion" and "reality," which, unfortunately, are left undefined.

W.C. ELLERBROEK, M.D.
Norwalk, Calif.

Contemporary Abnormal Psychology: Selected Readings, *edited by Brendan Maher. Baltimore, Penguin Books, 1973, 419 pp., $3.85 (paper).*

This excellent volume stands out amid the spate of run-of-the-mill "readings" books that have flooded the field of psychology in the past few years. It has all the earmarks of a labor of love, rather than of an academic potboiler. The editor, a distinguished researcher, scholar, and editor in his own right, has chosen 18 contributions to represent contemporary abnormal psychology, and he has selected them well. The papers are grouped into six sections—three under diagnosis and selection, six under schizophrenia, two under psychopathy, two under psychosomatic disorders, two under psychoneurotic disorders, and

three under contemporary developments in treatment. The papers *are* contemporary; they date from 1952 to 1971, with the main focus on the late 1960s.

The contributors are all recognized authorities. Some of the papers are familiar, i.e., Meehl's "Schizotaxia, Schizotypy, Schizophrenia," a favorite of anthologists (but who has said it better?). Together they offer an excellent, critical overview of today's experimental psychopathology. The errors, if any, are those of omission rather than inclusion. It already is a long book, and who would want any of the present selections displaced? The editor himself apologizes for the omission of psychopharmacology on the reasonable grounds that its concepts and terms lie outside the interest and training of many students in the field. Maher has contributed a critical introductory essay in which he calls for a psychopathology that is "firmly rooted in general behavioral science," and he introduces each section with some brief but pertinent comment.

The book is certainly no popular, do-it-yourself introductory guide to modern abnormal psychology for the man in the street. Its main use will probably be as a supplementary text for students in the field, but the mature professional reader will find it an invaluable library resource for orientation and reorientation in a complex and rapidly developing field.

The publisher has not done as felicitous a job. The book is small (four and one-half by seven inches) and fat and therefore difficult to handle. In addition, the print is quite small. Granted that Penguin format is Penguin format and that tradition must be maintained; nevertheless it seems a bit sadistic to temper the reader's pleasure with such ordeals of perusal.

WILLIAM A. HUNT, PH.D.
Chicago, Ill.

A System of Medical Hypnosis, *by Ainslie Meares, M.D., D.P.M. New York, Julian Press, 1972, 474 pp., $15.*

This is a 1972 reprint of a book originally published in 1960. Dr. Meares, an Australian psychiatrist, is actively involved with hypnotherapy and has been in contact through the years with the members of the Society for Clinical and Experimental Hypnosis in the United States. This volume is one of his significant professional writings and is appropriate for serious reading by experienced therapists.

The book is divided into five major sections—The Nature of Hypnosis, The Induction of Hypnosis, Suggestive Therapy, Hypnoanalysis, and Hypnosis in General Medicine. There is an introduction, glossary, selective bibliography, and index.

The author does not oversimplify. Rather, he writes in great detail about the complex issues connected with understanding and dealing with personalities of patients. His goal is to explain his own way of seeing problems and coping with them. He does not concern himself with the broader canvas of the opinions and methods of others, and the reader must be prepared for this one man's approach. Dr. Meares states in the introduction, however, that this is his intention: "There is a personal element in this account which has no place in a classic textbook. I have aimed rather to describe medical hypnosis as I practice it." The novice must keep this in mind, and the experienced hypnotherapist must accept this goal. The limited number of books on hypnosis in the selective bibliography reflects this approach. There are no journal references.

Among the many books available on hypnosis and hypnotherapy, most are second-rate and unfortunately are often misleading for the general and professional reader. But there is a core of high-quality material, especially for professionals, and Dr. Meares's contribution fits into this group.

JEROME M. SCHNECK, M.D.
New York, N.Y.

Marihuana—Deceptive Weed, *by Gabriel G. Nahas, M.D., Ph.D. New York, Raven Press, 1972, 326 pp., $12.50.*

Will anyone ever be able to write about marijuana without prejudice? Probably not. The next best choice would be that the author at least state his biases. From the pejorative title to the final chapter, the author of this book clearly places himself in the conservative camp, which maintains that use of marijuana is not all that harmless. Earlier books about marijuana, including reports of commissions, seemed to minimize, if not completely discount, any adverse effects of the drug. This book balances the scales so that both sides of the question can be considered.

If the reader's prejudices are not too affronted, he may find much that is good in the book. The initial chapter on the history of marijuana is about the best I have encountered. The next three chapters on the botany, chemistry, and pharmacology of the drug are also first-rate reviews. The chapter on the clinical pharmacology of the drug was somewhat of a disappointment; the discussion of this subject in the *First Report of the National Commission on Marihuana and Drug Abuse* (1) is better. Unfortunately, the author makes claims about man's rapid tolerance to marijuana that cannot be substantiated. The chapter on marijuana intoxication and mental illness is largely filled with direct quotations from Moreau; work done 125 years ago by a psychiatrist with the mistaken idea that hashish provided a model for naturally occurring psychoses is hardly germane to the hazards of present-day use of marijuana. The last chapter on social aspects of the drug is fairly comprehensive.

The book is better than its title would suggest. Despite its clear advocacy, it comes closest of all volumes thus far published to being a balanced and comprehensive review.

REFERENCE

1. Marihuana: A Signal of Misunderstanding. First Report of the National Commission on Marihuana and Drug Abuse. Washington, DC, US Government Printing Office, 1972

LEO E. HOLLISTER, M.D.
Palo Alto, Calif.

Clinical Practice in Community Mental Health Centers, *by H.G. Whittington, M.D. New York, International Universities Press, 1972, 157 pp., $8.50.*

This slender volume, designated a "manual" by an author well known in the field of community psychiatry, is a useful and highly practical contribution. It is concise and to the point, eschewing the excessive verbiage and padding often encountered even in manuals and handbooks; yet it is much more than a bare-bones skeleton. It is pithy and refreshingly frank, obviously the work of a practicing community psychiatrist and mental health center operator, but one who is well grounded in theory and basic knowledge.

This little book will prove a valuable companion, not only to the psychiatrist, but also to all professionals and paraprofessionals who are moving into the field of community mental health center practice without prior experience, training, or

other preparation for this expanding setting or its philosophical and methodological approach.

The book undoubtedly represents a condensation and reworking of the author's earlier work, *Psychiatry in the American Community* (1), but it is nevertheless timely and up-to-the-minute.

The first seven chapters are rigorously clinical and practical. The eighth and final chapter, titled "Recapitulation: Expectations and Opportunities," reflects the author's sense of "excitement and change inherent in the Community Mental Health Center movement in the United States today." He speaks of the community mental health practitioner as a "pragmatic Utopian" who has "set about to move our nation from the worst public mental health delivery system in the civilized world to the best." He is not above strongly held personal opinions (or bias), which adds zest and spice to what could otherwise be dry exposition.

REFERENCE

1. Whittington HG: Psychiatry in the American Community. New York, International Universities Press, 1966

RICHARD W. GARNETT, JR., M.D.
Charlottesville, Va.

The LSD Controversy: An Overview, *by Maurice S. Tarshis, Ph.D. Springfield, Ill., Charles C Thomas, 1972, 74 pp., $6.50.*

The LSD Controversy is apparently written primarily for teachers who have recently been assigned the task of "drug education," often without specialized training. For this purpose it is an almost excellent book. Its excellence lies in its simple, succinct, and understandable marshaling of both information and opinion about LSD. Its chapters discuss terminology, the issue of addiction and dependence, transportation and cost, the psychological and physical effects and complications of LSD (including chromosomal damage and teratogenicity), and medical and unsupervised patterns of use. The last chapter is an unusually complete and well-balanced summary of what is both known and unknown about LSD and is of concern to the issue of its safety when the drug is self-administered.

This book was published in November 1972. However, as the author notes, much of the material is unfortunately drawn from a paper published in 1967. This is reflected in the bibliography; with few exceptions (official documents, primarily) the papers referred to are drawn from earlier publications. As a result there are some factual errors, e.g., concerning the rate of excretion of LSD; however, for the purpose of this book they are insignificant. But more importantly, the degree of uncertainty concerning the reported chromosomal damage and teratogenicity is not adequately presented. Nowhere is it made clear that people take LSD and other drugs because they find the experience pleasurable. Drug use is different from drug abuse, and the relationship of LSD use to other drug use and the drug subculture is not discussed.

However, despite these omissions *The LSD Controversy* does provide clear and generally accurate information about LSD, and it will be a useful reference for those who require a nontechnical source of information.

WILLIAM A. FROSCH, M.D.
New York, N.Y.

Briefer Notice

Briefer notice does not imply a judgment; it simply means that the reviewers have evaluated the books in fewer words than in the previous section.

Behavior Modification: Principles and Clinical Applications, *edited by W. Stewart Agras, M.D. Boston, Little, Brown and Co., 1972, 213 pp., $11.50.*

Written primarily for the clinician with contributions from six authors, this book presents an overview of behavior therapies and their application to clinical problems.

Although such multi-authored endeavors usually tend to be uneven in quality, this is not the case here. The editor's brief introductory remarks about each therapy at the beginning of every chapter serve to give a smooth and cohesive account of the field of behavior modification.

Positive reinforcement and extinction procedures, token economy, and aversive and systematic desensitization approaches are described in detail. An excellent discussion of flooding by I. Marks and an annotated index of therapies conclude the book.

The narrative is simple and free of jargon. The emphasis throughout is on the description of the therapeutic techniques and their efficacy, and not on the usual polemics with the dynamic psychotherapies. The book is recommended to clinicians who want to learn about behavior modification techniques and to enlarge their therapeutic armamentarium.

PETER E. SIFNEOS, M.D.
Boston, Mass.

Science and Psychoanalysis, vol. 20: The Dynamics of Power, *edited by Jules H. Masserman, M.D. New York, Grune & Stratton, 1972, 209 pp., $12.50.*

This 20th volume of the Science and Psychoanalysis series, which has so enriched the psychiatric literature, differs considerably from the preceding volumes in both format and organization. A theoretical discussion of the various aspects of power is certainly timely in view of both the political and social preoccupations with power and the growing awareness that losing control of affairs is very much a part of the substructure of many present-day neuroses.

But this book is a potpourri without a correlating element except the title. The main body of the publication consists of the papers presented at the May 1971 scientific meeting of the American Academy of Psychoanalysis on the various aspects of power. However, the book begins with a survey of the international status of psychoanalysis and ends with the Bettelheim lecture on "The Inpatient Treatment of Psychotics" (the Frieda Fromm-Reichmann award lecture). Both of these essays have great value, but they are hardly consonant with the cental theme of the book.

Nonetheless, the book is interesting and instructive reading. There is an impressive range and breadth of scholarship in some unusual areas (Fortes' essay on "Machismo" and Masserman's exposition on Mary Todd and Abraham Lincoln are outstanding examples), and some of the clinical material is colorful and helpfully illustrative. As a series of loosely related essays,

The Dynamics of Power deserves careful and leisurely reading.

C.H. HARDIN BRANCH, M.D.
Santa Barbara, Calif.

Alcoholism and Driving, *by Carl J. Bridge, M.D. Springfield, Ill., Charles C Thomas, 1972, 81 pp., $7.*

This no-nonsense book is for everyone who has an interest in alcoholism and driving and should also be read by everyone who has an interest in alcoholism, for it is an established fact that most alcoholics do drive. Although Dr. Bridge is a psychiatrist who includes alcoholics on his patient roster, he came out of his medical cloister when he accepted a reality-oriented civic responsibility at the request of his local police department. He became involved in and personally contributed to the department's program by examining persons arrested on a charge of driving while intoxicated (DWI). Out of these experiences, he summarizes 200 cases in pertinent fashion.

This man is no starry-eyed idealist, reformed drunk, or zealot from Alcoholics Anonymous, but a commonsense physician who has given us the benefit of his experiences in a particular area. He points out leads that might be helpful in dealing with persons who have a problem with alcohol and with driving. Lest these comments be unfair, let his last paragraph speak for him: "Alcohol is here to stay, but many people must be kept away from it. We know alcoholics can be rehabilitated. We can all do something about it."

WILLIAM K. KELLER, M.D.
Louisville, Ky.

Brain's Clinical Neurology, *4th ed., revised by Roger Bannister, D.M. New York, Oxford University Press, 1973, 426 pp., $11.50 (paper).*

The new, fourth edition of *Brain's Clinical Neurology* is intended for physicians who wish to know the essentials of neurology. As in previous editions, the book is lucid and brief. In addition to discussing the clinical signs and symptoms of each disorder, it outlines the basic anatomy and physiology needed for an understanding of the disorder. For the most part, the book remains unchanged from previous editions. Brief mention is made of the concept of slow virus and its relation to neurologic disease. The book still includes a section on "Psychologic Diseases."

Brain's Clinical Neurology will serve as a useful supplemental text for those interested in neurology or as a text for anyone wishing to make a superficial review of neurology. It provides the bare essentials of clinical neurology and does so in an easily read and understood fashion and at a reasonable price.

DONALD W. MULDER, M.D.
Rochester, Minn.

This Month's Reviewers

HENRY I. SPITZ, M.D., is Assistant Clinical Professor of Psychiatry, New York Medical College, and Assistant Attending Psychiatrist, Flower and Fifth Avenue Hospitals, New York, N.Y.

GEORGE E. VAILLANT, M.D., is Associate Professor of Psychiatry, Harvard Medical School, Boston, Mass.

HENRY H. WORK, M.D., is Director, Professional Affairs, American Psychiatric Association, Washington, D.C.

PAUL H. BLACHLY, M.D., is Professor of Psychiatry, University of Oregon Medical School, Portland, Ore.

GRAHAM B. BLAINE, JR., M.D., is Assistant Psychiatrist, Adolescents' Unit, Children's Hospital Medical Center, Boston, Mass., and Consulting Psychiatrist, Simon's Rock Early College, Great Barrington, Mass.

W.C. ELLERBROEK, M.D., is Staff Psychiatrist, Metropolitan State Hospital, Norwalk, Calif.

WILLIAM A. HUNT, PH.D., is Professor of Psychology, Loyola University of Chicago, Chicago, Ill.

JEROME M. SCHNECK, M.D., is Attending Psychiatrist, Division of Psychiatric Training and Education, St. Vincent's Hospital and Medical Center, New York, N.Y.; he is also in private practice.

LEO E. HOLLISTER, M.D., is Medical Investigator, Veterans Administration Hospital, Palo Alto, Calif.

RICHARD W. GARNETT, JR., M.D., is Clinical Director, Blue Ridge Mental Health Center, Charlottesville, Va.

WILLIAM A. FROSCH, M.D., is Professor of Psychiatry and Director of Graduate Education in Psychiatry, New York University School of Medicine, New York, N.Y.

PETER E. SIFNEOS, M.D., is Associate Director, Department of Psychiatry, Beth Israel Hospital, and Associate Professor of Psychiatry, Harvard Medical School, Boston, Mass.

C.H. HARDIN BRANCH, M.D., is Program Chief, Santa Barbara County Mental Health Services, Santa Barbara, Calif.

WILLIAM K. KELLER, M.D., is Professor and Chairman, Department of Psychiatry, University of Louisville School of Medicine, Louisville, Ky.

DONALD W. MULDER, M.D., is Consultant, Department of Neurology, Mayo Clinic, Rochester, Minn.

Books Received

This listing acknowledges the receipt of recent books. Books of particular interest to the readers of this journal will be reviewed as space permits, and copies of the reviews will be sent to the publishers. Books cannot be returned to the publishers.

AMA Drug Evaluations, *2nd ed., prepared by the AMA Department of Drugs. Acton, Mass., Publishing Sciences Group, 1973, 1031 pp., $22, institutions and non-AMA members; $16.50, AMA members and students.*

Rorschach Responses in Old Age, *revised ed., by Louise Bates Ames, Ph.D., Ruth W. Métraux, M.A., Janet Learned Rodell, Ph.D., and Richard N. Walker, Ph.D. New York, Brunner/Mazel, 1973, 211 pp., $12.50.*

Dream Keepers: The Young Brontës. A Psycho-Biographical Novella, *by Jane Amster. New York, William-Frederick Press, 1973, 96 pp., $4.50.*

Skid Row: An Introduction to Disaffiliation, *by Howard M. Bahr. New York, Oxford University Press, 1973, 324 pp., $3.95 (paper).*

The Mind Is a Funny Thing, *by Barry R. Berkey, M.D., and Velma A. Berkey. Minneapolis, T.S. Denison & Co., 1973, 45 pp., $4.99.*

Acting-In: Practical Applications of Psychodramatic Methods, *by Howard A. Blatner, M.D. New York, Springer Publishing Co., 1973, 150 pp., $5.25 (paper).*

Psychiatry in the Everyday Practice of Law, *by Martin Blinder, M.D. Rochester, N.Y., Lawyers Co-operative Publishing Co., 1973, 292 pp., no price listed.*

Aging and Behavior, *by Jack Botwinick, Ph.D. New York, Springer Publishing Co., 1973, 314 pp., $10.50.*

Inside Psychotherapy, *edited by Adelaide Bry. New York, New American Library, 1973, 173 pp., $1.25 (paper).*

Policy for Action: A Symposium on the Planning of a Comprehensive District Psychiatric Service, *edited by Robert Cawley and Gordon McLachlan. New York, Oxford University Press, 1973, 187 pp., $9.50 (paper).*

Treatment of the Insane Without Mechanical Restraints, *by John Conolly, M.D. (reprint). London, Dawsons of Pall Mall, 1973, 380 pp., £7.50.*

The Place Where The World Ends: A Modern Story of Cannibalism and Human Courage, *by Richard Cunningham. New York, Sheed and Ward, 1973, 208 pp., $5.95.*

Socialization for Achievement: Essays on the Cultural Psychology of the Japanese, *by George A. De Vos. Berkeley, University of California Press, 1973, 582 pp., $20.*

What Can We Do About Limited Vision? *by Irving R. Dickman. Public Affairs Pamphlet No. 491. New York, Public Affairs Committee, 1973, 28 pp., 35¢ (paper).*

The Bill of Rights Today, *by Thomas I. Emerson. Public Affairs Pamphlet No. 489. New York, Public Affairs Committee, 1973, 28 pp., 35¢ (paper).*

Neurochemistry of Cerebral Electroshock, *by Walter B. Essman. New York, Halsted Press, John Wiley & Sons (distributor), 1973, 167 pp., no price listed.*

Eysenck on Extraversion, *by H.J. Eysenck. New York, Halsted Press, John Wiley & Sons, 1973, 174 pp., $4.95 (paper).*

A Bibliography of Noise for 1971, *compiled by Mary K. Floyd. Troy, N.Y., Whitston Publishing Co., 1973, 145 pp., $10.*

The Vanishing Adolescent, *by Edgar Z. Friedenberg (1959). Boston, Beacon Press, 1973, 144 pp., $3.95 (paper).*

MBD: The Family Book about Minimal Brain Dysfunction, *by Richard A. Gardner, M.D. New York, Jason Aronson, 1973, 185 pp., $7.95.*

Understanding Children, *by Richard A. Gardner, M.D. New York, Jason Aronson, 1973, 249 pp., $10.*

Sexual Suicide, *by George F. Gilder. New York, Quadrangle/New York Times Book Co., 1973, 294 pp., $7.95.*

Humane Reproduction, *by the Group for the Advancement of Psychiatry. Report No. 86. New York, GAP, 1973, 113 pp., $4 (paper).*

From Diagnosis to Treatment: An Approach to Treatment Planning for the Emotionally Disturbed Child, *by the Group for the Advancement of Psychiatry. Report No. 87. New York, GAP, 1973, 146 pp., $4 (paper).*

Social Competence and Mental Handicap: An Introduction to Social Education, *2nd ed., by H.C. Gunzburg, Ph.D. Baltimore, Williams & Wilkins Co. (U.S. agents), 1973, 230 pp., $13.25.*

A Primer of Jungian Psychology, *by Calvin S. Hall and Vernon J. Nordby. New York, Taplinger Publishing Co., 1973, 136 pp., $5.95.*

Parents and Teenagers, *by Margaret Hill. Public Affairs Pamphlet No. 490. New York, Public Affairs Committee, 1973, 24 pp., 35¢ (paper).*

Behavior Disorders of Childhood and Adolescence, *by Richard L. Jenkins, M.D. Springfield, Ill., Charles C Thomas, 1973, 132 pp., $6.95*

Youth and Sex: Pleasure and Responsibility, *by Gordon D. Jensen, M.D. Chicago, Nelson-Hall Co., 1973, 151 pp., $6.95.*

The Process of Psychotherapy: Empirical Foundations and Sys-

tems of Analysis, *by Donald J. Kiesler, Ph.D. Chicago, Aldine Publishing Co., 1973, 449 pp., $15.*

Tom Tom, *by Thomas F. Lalor. New York, Harper & Row, 1973, 106 pp., $4.95.*

The Technique of Psychoanalytic Psychotherapy, vol. 1, *by Robert Langs, M.D. New York, Jason Aronson, 1973, 632 pp., $15.*

Law and Ethics of A.I.D. and Embryo Transfer. *Ciba Foundation Symposium 17. New York, American Elsevier Publishing Co. (distributor), 1973, 103 pp., $6.50.*

Poetry the Healer, *edited by Jack J. Leedy, M.D. Philadelphia, J.B. Lippincott Co., 1973, 214 pp., $8.95.*

Tahitians: Mind and Experience in the Society Islands, *by Robert I. Levy. Chicago, University of Chicago Press, 1973, 529 pp., $12.50.*

The Mentally Retarded Child and His Family, *by Harold D. Love, Ed.D. Springfield, Ill., Charles C Thomas, 1973, 198 pp., $7.95.*

A Triune Concept of the Brain and Behaviour: The Clarence M. Hincks Memorial Lectures, 1969, *by Paul D. MacLean, M.D., edited by T.J. Boag, M.D., and D. Campbell, Ph.D. Toronto, University of Toronto Press, 1973, 165 pp., $9.50.*

Psychodiagnosis: Selected Papers, *by Paul E. Meehl. Minneapolis, University of Minnesota Press, 1973, 323 pp., $14.50.*

Theory of Psychoanalytic Technique, *2nd ed., by Karl A. Menninger, M.D., and Philip S. Holzman, Ph.D. New York, Basic Books, 1973, 201 pp., $7.95.*

The Kindergarten Teacher's Handbook, *by Elizabeth S. Meyers, Helen H. Ball, and Marjorie Crutchfield. Los Angeles, Gramercy Press, 1973, 99 pp., $2.95 (paper).*

Assessment for Learning in the Mentally Handicapped, *edited by Peter Mittler, Ph.D. Baltimore, Williams & Wilkins Co. (U.S. agents), 1973, 305 pp., $20.25.*

Activities Therapy, *by Anne Cronin Mosey, Ph.D. New York, Raven Press, 1973, 195 pp., $9.75.*

An Introduction to Art Therapy, *revised ed., by Margaret Naumburg. New York, Teachers College Press, 1973, 225 pp., $10.*

Mothers and Daughters: A Lifelong Relationship, *revised ed., by Edith G. Neisser. New York, Harper & Row, 1973, 382 pp., $10.*

Securing the Legal Rights of Retarded Persons, *by Elizabeth Ogg. Public Affairs Pamphlet No. 492. New York, Public Affairs Committee, 1973, 27 pp., 35¢ (paper).*

Clinical Aspects of Dementia, *by John Pearce, M.D. Baltimore, Williams & Wilkins Co. (U.S. agents), 1973, 142 pp., $13.25.*

ESP Research Today: A Study of Developments in Parapsychology Since 1960, *by J. Gaither Pratt, Ph.D. Metuchen, N.J., Scarecrow Press, 1973, 186 pp., $6.*

Problemi di Psichiatria, N. 5. *Aversa, Italy, Ospedale Psichiatrico S. Maria Maddalena, 1973, 211 pp., no price listed (paper).*

A Second Look at Life. Transplantation and Dialysis Patients: Their Own Stories, *edited by Felix T. Rapaport, M.D. New York, Grune & Stratton, 1973, 91 pp., $5.95.*

The Psychoses: Family Studies, *by Sheldon C. Reed, Ph.D., Carl Hartley, Ph.D., V. Elving Anderson, Ph.D., Vivian P. Phillips, and Nelson A. Johnson, M.S.W. Philadelphia, W.B. Saunders Co., 1973, 573 pp., $19.*

El abuso de las drogas—qué podemos hacer? *by Jules Saltman. Public Affairs Pamphlet No. 390A. New York, Public Affairs Committee, 1973, 28 pp., 35 ¢ (paper).*

The Patient and the Analyst: The Basis of the Psychoanalytic Process, *by Joseph Sandler, M.D., D.Sc., Ph.D., Christopher Dare, M.B., B.Chir., D.P.M., and Alex Holder, D. Phil. New York, International Universities Press, 1973, 143 pp., $10.*

Current Issues in Adolescent Psychiatry, *edited by Joseph C. Schoolar, Ph.D., M.D. New York, Brunner/Mazel, 1973, 262 pp., $12.50.*

Ergebnisse zur Sexualmedizin, *2nd ed., edited by Volkmar Sigusch. New York, S. Karger, 1973, 179 pp., $5.20 (paper).*

When People Need Help, *by Maxwell S. Stewart. Public Affairs Pamphlet No. 493. New York, Public Affairs Committee, 1973, 23 pp., 35¢ (paper).*

The Wish To Be Free: Society, Psyche, and Value Change, *by Fred Weinstein and Gerald M. Platt. Berkeley, University of California Press, 1973, 309 pp., $3.85 (paper).*

Movement and Drama in Therapy, *by Audrey Wethered. Boston, Plays, 1973, 126 pp., $8.95.*

Dealing with Deviants: The Treatment of Antisocial Behavior, *by Stuart Whiteley, Dennie Briggs, and Merfyn Turner. New York, Schocken Books, 1973, 239 pp., $8.50.*

Victims of Success: Emotional Problems of Executives, *by Benjamin B. Wolman. New York, Quadrangle/New York Times Book Co., 1973, 160 pp., $5.95.*

ANNUAL INDEX

Following is the comprehensive index for volume 130 of the *Journal*, covering all material from January 1973 through December 1973. The complete citation for each article in the author index is listed under the name of the first author; joint authors are listed alphabetically with a cross reference to the full citation. Book reviews appear in the author index under the name of the reviewer and in the subject index under the heading Book Reviews; the books are arranged alphabetically by the surname of the book's first author.

Entries other than regular articles and brief communications are indicated as such by the following designations: (Editorial); (Ltr to Ed), Letter to the Editor; (In Mem), In Memoriam; and (Off Acts), Official Actions.

Author Index

Abrahamsen D: Book Review of V Carasov: Two Gentlemen To See You, Sir: The Autobiography of a Villain, 232–233, Feb 1973
Abrams R: discussion of GM Henry, H Weingartner, DL Murphy, Influence of affective states and psychoactive drugs on verbal learning and memory, 971, Sept 1973
Abrams R: see SanGiovanni F, jt au
Abrams S: The polygraph in a psychiatric setting, 94–98, Jan 1973
Ackerman RE: see Prince RM Jr, jt au
Adams PL: Functions of the lower-class partial family, 200–203, Feb 1973
Adler G: Hospital treatment of borderline patients, 32–35, Jan 1973
Adler HM, Hammett VBO: Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, 861–864, Aug 1973
Agras WS: see Wolpe J, jt au
Alderfer CP: see Hammerschlag CA, jt au
Aledort SL, Jones M: The Euclid House: a therapeutic halfway house for prisoners, 286–289, Mar 1973
Allen MG: Psychiatry in the United States and the USSR: a comparison, 1333–1337, Dec 1973
Allen RP: see Safer DJ, jt au
Alperin L: see Lowinson J, jt au
Alpert M: see Marcos LR, jt au
Alterman AI: see Gottheil E, jt au
Altman H: Female patients: intractable or victims of chauvinism? (Ltr to Ed), 495, April 1973
Altman H: see Evenson RC, jt au
Altman H: see Sletten IW, jt au
Altman N: see Sachar EJ, jt au
Ananth JV, Valles JV, Whitelaw JP: Usual and unusual agranulocytosis during neuroleptic therapy, 100–102, Jan 1973
Anderson FE: Marijuana flashbacks (Ltr to Ed), 1399, Dec 1973
Anderson RW: see Garetz FK, jt au
Anthony EJ: Book Review of S Chess, A Thomas (eds): Annual Progress in Child Psychiatry and Child Development: 1971, 336–337, Mar 1973
Appel KE, Morris HH Jr: Book Review of H Kelman: Helping People: Karen Horney's Psychoanalytic Approach, 112–113, Jan 1973
Arensdorf AM: see McDermott JF Jr, jt au
Aring CD: Aggression and social synergy (Editorial), 297–298, Mar 1973
Aring CD: Book Review of S Arieti: The Will To Be Human, 501, April 1973
Aring CD: Book Review of B Bursten: The Manipulator: A Psychoanalytic View, 1302, Nov 1973
Arnold LE, Kirilcuk V, Corson SA, Corson E O'L: Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, 165–170, Feb 1973
Aronson H: see Panzetta AF, jt au
Arthur RJ: see Rahe RH, jt au
Arthur RJ: Social psychiatry: an overview, 841–849, Aug 1973
Artiss KL: Book Review of HS Sullivan (ed by HS Perry, ML Gawel, M Gibbon): Clinical Studies in Psychiatry, 1047, Sept 1973
Asher H: Are methadone withdrawal patients overprotected? (Ltr to Ed), 1041–1042, Sept 1973
Auer ET: The Council on Emerging Issues (Off Acts), 514–515, April 1973
Auerbach J: see Miller MH, jt au
Auvenshine CD: see Finney JC, jt au
Awad GA: see Pederson AM, jt au
Axelrod J: see Wyatt RJ, jt au
Axelson AA: see Scanlan JM, jt au

Baker GA: Effects of nutrition on schizophrenia (Ltr to Ed), 1400, Dec 1973
Balcanoff EJ: see Bendt RH, jt au
Balser BH: Book Review of E Pavenstedt, VW Bernard (eds): Crises of Family Disorganization: Programs to Soften Their Impact on Children, 230–231, Feb 1973
Balser BH: Book Review of SJ Shamsie (ed): Youth: Problems and Approaches, 831, July 1973
Balter MB: see Manheimer DI, jt au
Baram D: see Kane FJ Jr, jt au
Barber WH, Lurie HJ: Designing an experientially based continuing education program, 1148–1150, Oct 1973
Barksdale BS: see Prince RM Jr, jt au
Barocas CB: see Barocas HA, jt au
Barocas HA, Barocas CB: Manifestations of concentration camp effects on the second generation, 820–821, July 1973
Barry MJ Jr: Book Review of M Balint, PH Ornstein, E Balint: Focal Psychotherapy: An Example of Applied Psychoanalysis, 828–829, July 1973
Barry MJ Jr: Book Review of HB Lewis: Shame and Guilt in Neurosis, 615, May 1973
Bartolucci G, Drayer CS: An overview of crisis intervention in the emergency rooms of general hospitals, 953–960, Sept 1973
Barton D: Teaching psychiatry in the context of dying and death, 1290–1291, Nov 1973
Barton FD: Even mental health jargon can be funny (Ltr to Ed), 495, April 1973
Barton WE: Report of the Medical Director (Off Acts), 1187–1188, Oct 1973
Bates DE: see Gottschalk LA, jt au
Beaubrun MH, Knight F: Psychiatric assessment of 30 chronic users of cannabis and 30 matched controls, 309–311, Mar 1973
Beck AT: see Minkoff K, jt au
Beck JC: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 224, Feb 1973
Beck R: see Minkoff K, jt au
Becker RE: Psychiatry in undergraduate medical education (Editorial), 586–587, May 1973
Becker RE, Wintrob RM, Cancro R, Stabenau JR: Psychiatry in the functionally organized curriculum, 571–574, May 1973
Bednar RA: see Rogeness GA, jt au
Beigel A, Bower WH, Levenson AI: A unified system of care: blueprint for the future, 554–558, May 1973
Beiser M, Burr WA, Ravel J-L, Collomb H: Illnesses of the spirit among the Serer of Senegal, 881–886, Aug 1973
Belmaker R: see Wyatt RJ, jt au
Bender L: The life course of children with schizophrenia, 783–786, July 1973
Bendt RH, Balcanoff EJ, Tragellis GS: Incompetency to stand trial: is psychiatry necessary? 1288–1289, Nov 1973
Benedek EP: Training the woman resident to be a psychiatrist, 1131–1135, Oct 1973
Bennett D: Community mental health services in Britain, 1065–1070, Oct 1973
Bennett L: see Rahe RH, jt au
Berg D: see Hammerschlag CA, jt au
Berger J: Voluntary faculty in psychiatric education (Ltr to Ed), 823–824, July 1973
Berger MM: A preliminary report on multi-image immediate video self-confrontation, 304–306, Mar 1973
Bergman E: see Minkoff K, jt au
Bergman RL: A school for medicine men, 663–666, June 1973
Bergner L: see Blumenthal S, jt au
Bergner P-eE: see Cooper TB, jt au
Bernard V, Bullette J, Gorney R, Grinspoon L, Handler J, Marmor J, Menninger R, Ottenberg P, Smith K, Wilkerson R: The role of psychiatry in war and poverty (Ltr to Ed), 109, Jan 1973
Bernard VW: About psychiatry, psychiatrists, and social problems (Editorial), 204–205, Feb 1973
Bess B: see Janus S, jt au

Betwee J: Broken promises (Ltr to Ed), 1163, Oct 1973
Bialer I: see Brown D, jt au
Bieber I: see Stoller RJ, jt au
Bielen L: see Gordon RE, jt au
Bigelow G: see Liebson I, jt au
Billingsley TH: see Scanlan JM, jt au
Birkett DP: A myth unmythed (Ltr to Ed), 329, Mar 1973
Bitensky R: The road to Shangri-La is paved with vitamins, 1253–1256, Nov 1973
Blachly PH: Book Review of A Alvarez The Savage God: A Study of Suicide, 1405–1406, Dec 1973
Blachly PH: Drug dosage in ECT (Ltr to Ed), 1293, Nov 1973
Bladholm S: see Lassers E, jt au
Blaine GB Jr: Book Review of JD Matarazzo, AE Bergin, JD Frank, PJ Lang, IM Marks, HH Strupp (eds): Psychotherapy: 1971, 1406, Dec 1973
Blank JE: Empty hospital beds and human misery (Ltr to Ed), 1401–1402, Dec 1973
Bleuler M: Some aspects of the history of Swiss psychiatry, 991–994, Sept 1973
Block SL: Book Review of LR Wolberg, EK Schwartz (eds): Group Therapy: 1973—An Overview, 1170–1171, Oct 1973
Bloom JD: Migration and psychopathology of Eskimo women, 446–449, April 1973
Bloom V: Book Review of D Lester: Why People Kill Themselves: A Summary of Research Findings on Suicidal Behavior, 1048–1049, Sept 1973
Bloomberg S: Problems associated with the introduction of a psychiatric unit into a rural general hospital, 28–31, Jan 1973
Blos P Jr: Book Review of MF Mayer (compiler and ed), A Blum: Healing Through Living: a symposium on Residential Treatment, 832, July 1973
Blumenthal MD: Resentment and suspicion among American men, 876–880, Aug 1973
Blumenthal RS: see Crumley FE, jt au
Blumenthal S, Bergner L: Suicide and newspapers: a replicated study, 468–471, April 1973
Bolman WM: reply to PA Roemer, Psychiatrists in the ghetto (Ltr to Ed), 720, June 1973
Bolman WM: see McDermott JF Jr, jt au
Bolton JM: see Kinzie JD, jt au
Boren CW: Book Review of DH Efron (ed): Psychotomimetic Drugs, 945–946, Aug 1973
Boren CW: Book Review of B Maletzky, PH Blachly: The Use of Lithium in Psychiatry, 333–334, Mar 1973
Borus JF: Reentry: I. "making it" back in the States, 850–854, Aug 1973
Bower WH: see Beigel A, jt au
Braceland FJ: Book Review of British Medical Association Journal Department: The Mental Health Service after Unification: Mental Health in a Unified National Health Service—Report of the Tripartite Committee, 333, Mar 1973
Braceland FJ: Book Review of Drug Use in America: Problems in Perspective. Second Report of the National Commission on Marihuana and Drug Abuse, 1164–1165, Oct 1973
Braceland FJ: Book Review of LC Kolb: Modern Clinical Psychiatry, 8th ed, 943–944, Aug 1973
Braceland FJ: Book Review of ES Shneidman (ed): Death and the College Student: A Collection of Brief Essays on Death and Suicide by Harvard Youth, 113, Jan 1973
Braceland FJ: Editor's note to G Gardos, The need for feedback to authors (Ltr to Ed), 825, July 1973
Braceland FJ: Fewer special sections in the offing (Editorial), 1020–1021, Sept 1973
Braceland FJ: Kudos (Editorial), 473, April 1973
Braceland FJ: More changes for the *Journal* (Editorial), 205–206, Feb 1973
Braceland FJ: A year of change—a card of thanks (Editorial), 89–91, Jan 1973
Brady JP: Book Review of BE Eleftheriou, JP Scott (eds): The Physiology of Aggression and Defeat, 335–336, Mar 1973
Brady JP: Book Review of RP Liberman: A Guide to Behavioral Analysis and Therapy, 615–616, May 1973
Brady JP: see Wolpe J, jt au
Braff DL: Clinical and theoretical consequences of the misuse of basic behavior therapy concepts, 818–819, July 1973
Branch CHH: Book Review of JH Masserman (ed): Current Psychiatric Therapies, vol 11, 336, Mar 1973
Branch CHH: Book Review of JH Masserman (ed): Science and Psychoanalysis, vol XX: The Dynamics of Power, 1408–1409, Dec 1973
Bransford D: see Cline DW, jt au
Braun M: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 225, Feb 1973
Breggin PR: reply to E Revitch, Lobotomies defended (Ltr to Ed), 609, May 1973
Brenneis CB, Laub D: Current strains for mental health trainees, 41–45, Jan 1973
Brenneis CB, Laub D: reply to W Reich, Activist and traditionalist approaches in psychiatry (Ltr to Ed), 825–826, July 1973
Bridge TP, Ellinwood EH Jr: Quaalude alley: a one-way street, 217–219, Feb 1973
Brill NQ: Book Review of G Usdin (ed): Perspectives on Violence, 234–235, Feb 1973
Brill NQ: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 223, Feb 1973
Brill NQ: see Hochman JS, jt au
Brodie HKH: see Murphy DL, jt au
Brodie HKH, Sabshin M: An overview of trends in psychiatric research: 1963–1972, 1309–1318, Dec 1973
Brody EB: The psychiatrist and family planning (Editorial), 1273–1274, Nov 1973
Brody EB: see Miller MH, jt au
Brooks BGB: Postgraduate training in child psychiatry: the content of the curriculum, 491–493, April 1973
Brosin HW: Book Review of DD Steinberg, LA Jakobovits (eds): Semantics: An Interdisciplinary Reader in Philosophy, Linguistics and Psychology, 1166–1167, Oct 1973
Brosin HW: Perry Clement Talkington, M.D., one hundred and first President, 1972–1973, 750–753, July 1973
Brown BS, Kozel NJ, Meyers MB, DuPont RL: Use of alcohol by addict and nonaddict populations, 599–601, May 1973
Brown D, Winsberg BG, Bialer I, Press M: Imipramine therapy and seizures: three children treated for hyperactive behavior disorders, 210–212, Feb 1973
Brown WA: see Keating GW, jt au
Bryntwick S: see Solyom L, jt au
Bucky SF: The relationship between background and extent of heroin use, 709–710, June 1973
Bullette J: see Bernard V, jt au
Bunney WE Jr: see Murphy DL, jt au
Burr WA: see Beiser M, jt au
Butler RN: Book Review of S de Beauvoir: The Coming of Age, 331–332, Mar 1973
Cadoret R: see Zalcman S, jt au
Caffey EM Jr: discussion of RC Evenson, H Altman, IW Sletten, RR Knowles, Factors in the description and grouping of alcoholics, 53–54, Jan 1973
Caffey EM Jr: discussion of KR MacKenzie, The eclectic approach to the treatment of phobias, 1106, Oct 1973
Caldwell JM: Book Review of CJ Williams, MS Weinberg: Homosexuals and the Military, 1172–1173, Oct 1973
Callan JP, Patterson CD: Patterns of drug abuse among military inductees, 260–264, Mar 1973
Campbell RJ: Book Review of DJ Holmes: Psychotherapy: Experience, Behavior, Mentation, Communication, Culture, Sexuality, and Clinical Practice, 944, Aug 1973
Campbell RJ: Book Review of PE Sifneos: Short-Term Psychotherapy and Emotional Crisis, 499–500, April 1973
Cancro R: see Becker RE, jt au
Cancro R: The treatment of schizophrenia: illusion or elusion? (Editorial), 693–694, June 1973
Carman JS: Imipramine in hyperacusic depression (Ltr to Ed), 937, Aug 1973

Carmichael HT: reply to M Malcolm and to HL Newbold, Assessing Self-Assessment (Ltrs to Ed), 1162, Oct 1973
Carson JE: see Vidaver RM, jt au
Carter WB: see Scanlan JM, jt au
Chagoya L: see Sigal JJ, jt au
Chameides WA, Yamamoto J: Referral failures: a one-year follow-up, 1157–1158, Oct 1973
Chang SC, Kim K-i: Psychiatry in South Korea, 667–669, June 1973
Chapel JL: Emergency room treatment of the drug-abusing patient, 257–259, Mar 1973
Chapel JL: reply to R Kalda and to GA Rogers, Chlorpromazine contraindicated in delirium tremens (Ltrs to Ed), 1043, Sept 1973
Char WF: see McDermott JF Jr, jt au
Charatan FB: Book Review of JA Baldwin: The Mental Hospital in the Psychiatric Service: A Case-Register Study, 501–502, April 1973
Chaudhry ZA: see Hussain MZ, jt au
Chien C-p: see Kazamatsuri H, jt au
Chien C-p, Cole JO: Depot phenothiazine treatment in acute psychosis: a sequential comparative clinical study, 13–18, Jan 1973
Chien C-p, Cole JO: Landlord-supervised cooperative apartments: a new modality for community-based treatment, 156–159, Feb 1973
Chien C-p, Cole JO: reply to JB Schoonmaker, Danger of depot phenothiazine treatment in acute psychosis (Ltr to Ed), 723, June 1973
Chien C-p, Stotsky BA, Cole JO: Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, 543–548, May 1973
Chiles JA: see Greist JH, jt au
Chinoy MP: Biochemical aspects of sensitivity reactions (Ltr to Ed), 1402, Dec 1973
Cho DW: see Sletten IW, jt au
Chodoff P: Book Review of E Freidson: Profession of Medicine: A Study of the Sociology of Applied Knowledge, 498–499, April 1973
Chodoff P: see Schimel JL, jt au
Choi SY: Dreams as a prognostic factor in alcoholism, 699–702, June 1973
Christopher P: see Resnik HLP, jt au
Cisin IH: see Manheimer DI, jt au
Cleary MF: The writ writer, 319–322, Mar 1973
Climent CE, Rollins A, Ervin FR, Plutchik R: Epidemiological studies of women prisoners, I: medical and psychiatric variables related to violent behavior, 985–990, Sept 1973
Cline DW, Garrard JN: Evaluation of the SAID teaching program, 582–585, May 1973
Cline DW, Garrard JN: A medical interviewing course: objectives, techniques, and assessment, 574–578, May 1973
Cline DW, Rouzer DL, Bransford D: Goal-attainment scaling as a method for evaluating mental health programs, 105–108, Jan 1973
Cohen S: see Wyatt RJ, jt au
Cole JO: see Chien C-p, jt au
Cole JO: see Kazamatsuri H, jt au
Collins RT: Book Review of JJ Leedy (ed): Compensation in Psychiatric Disability and Rehabilitation, 727, June 1973
Collomb H: see Beiser M, jt au
Conner DR: see Fiman BG, jt au
Conrad FE: see U'Ren RC, jt au
Cooke G, Johnston N, Pogany E: Factors affecting referral to determine competency to stand trial, 870–875, Aug 1973
Cooper TB, Bergner P-eE, Simpson GM: The 24-hour serum lithium level as a prognosticator of dosage requirements, 601–603, May 1973
Cooper TB, Simpson GM: Concomitant imipramine and methylphenidate administration (Ltr to Ed), 721, June 1973
Corral H: Statements about Viet Nam: APA's role (Ltr to Ed), 721–722, June 1973
Corson E O'L: see Arnold LE, jt au
Corson SA: see Arnold LE, jt au
Cotton JM: Sandor Rado, 1890–1972 (In Mem), 222, Feb 1973
Cox VM Jr: "Diagnosing" political candidates (Ltr to Ed), 109–110, Jan 1973
Coyne L: see Fried FE, jt au
Crane GE: Is tardive dyskinesia a drug effect? (Ltr to Ed), 1043, Sept 1973
Crane GE: Rapid reversal of tardive dyskinesia (Ltr to Ed), 1159, Oct 1973
Crawford JW, Crawford S: Psychiatry and group medical practice: the diagnostic process, referral patterns, and utilization of services, 637–642, June 1973
Crawford S: see Crawford JW, jt au
Crumley FE, Blumenthal RS: Children's reactions to temporary loss of the father, 778–782, July 1973
Cserr R: discussion of EF Torrey, RL Taylor, Cheap labor from poor nations, 433–434, April 1973
Curran JP: Management of tardive dyskinesia with thiopropazate, 925–927, Aug 1973
Curran JP: reply to GE Crane, Is tardive dyskinesia a drug effect? (Ltr to Ed), 1043–1044, Sept 1973
Curran JP: Tardive dyskinesia: side effect or not? 406–410, April 1973
Curry MD: see Talbott JA, jt au
Cutler R: see Nir Y, jt au
Cytryn L: see McKnew DH Jr, jt au

Dalle-Molle D: see Marohn RC, jt au
Daniels RS: Changing human service delivery systems: their influences on psychiatric training, 1232–1236, Nov 1973
Daniels RS: The crisis of financing residency training in psychiatry: a diagnosis (Ltr to Ed), 496–497, April 1973
Davidson HA: Book Review of AM Freedman, HI Kaplan, BJ Sadock: Modern Synopsis of *Comprehensive Textbook of Psychiatry*, 613–614, May 1973
Davidson ST: see Manheimer DI, jt au
Davis G: see Greenberg RP, jt au
Davis JM: Biological psychiatry (Editorial), 87–88, Jan 1973
Davis JM: see El-Yousef MK, jt au
Davis JM: see Fann WE, jt au
Davis JM: see Janowsky DS, jt au
Davison WT: see Resnik HLP, jt au
Dean SR: Metapsychiatry: the interface between psychiatry and mysticism, 1036–1038, Sept 1973
Decker JB: Book Review of LC Kolb, VW Bernard, BP Dohrenwend: Urban Challenges to Psychiatry, 725, June 1973
Deem MA: see Greenberg LM, jt au
De la Torre J: discussion of SH Lipsius, Judgments of alternatives to hospitalization, 895–896, Aug 1973
Detre T: see Kupfer DJ, jt au
Diethelm O: Book Review of M Bleuler: Die schizophrenen Geistesstörungen, 332, Mar 1973
Diethelm O: Book Review of E Kraepelin (tr by RM Barclay): Dementia Praecox and Paraphrenia (facsimile edition), 1167–1168, Oct 1973
DiGiacomo J: see Mendels J, jt au
DiPasquale D: see Weinstein AS, jt au
Dohan FC: reply to GA Baker, Effects of nutrition on schizophrenia (Ltr to Ed), 1400–1401, Dec 1973
Dohan FC, Grasberger JC: Relapsed schizophrenics: earlier discharge from the hospital after cereal-free, milk-free diet, 685–688, June 1973
Doherty EG: see Fried FE, jt au
Dols LCW: see Van Praag HM, jt au
Donahue HH: Report of the Treasurer (Off Acts), 1184–1186, Oct 1973
Donlon PT, Rada RT, Knight SW: A therapeutic aftercare setting for "refractory" chronic schizophrenic patients, 682–684, June 1973
Donnelly J: Book Review of JG Howells (ed): Modern Perspectives in World Psychiatry, 229–230, Feb 1973
Donnelly J: Book Review of BF Skinner: Beyond Freedom and Dignity, 1047–1048, Sept 1973
Dorsey EC: Psychiatry and neurology (Ltr to Ed), 110–111, Jan 1973
Drayer CS: Book Review of DJ Carek: Principles of Child Psychotherapy, 232, Feb 1973
Drayer CS: see Bartolucci G, jt au
Drummond GI: see Perry TL, jt au
Drye RC: reply to R Grumet, No-suicide decisions: a procedural rule (Ltr to Ed), 1163, Oct 1973
Drye RC, Goulding RL, Goulding ME: No-suicide decisions: patient monitoring of suicidal risk, 171–174, Feb 1973
Dunner DL: see Fieve RR, jt au
Dunner DL: see Goodwin FK, jt au
DuPont RL: see Brown BS, jt au

Durell J: Book Review of J-O Miller: The Therapeutic Community with Chronic Mental Patients, 334, Mar 1973
Dwyer TF: Telepsychiatry: psychiatric consultation by interactive television, 865–869, Aug 1973
Dyrud JE, Holzman PS: The psychotherapy of schizophrenia: does it work? 670–673, June 1973

Eaton JS Jr: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 223, Feb 1973
Edgerton RB: Book Review of BH Kaplan (ed), AH Leighton, JM Murphy, N Freydberg: Psychiatric Disorder and the Urban Environment, 233–234, Feb 1973
Ehrenwald J: Psyching out psi (Ltr to Ed), 328–329, Mar 1973
Eisdorfer C: see Hawkins DM, jt au
Ellerbroek WC: Book Review of BR Berkey: Halfway Through the Tunnel, 1406, Dec 1973
Ellinwood EH Jr: see Bridge TP, jt au
Ellinwood EH Jr, Sudilovsky A, Nelson LM: Evolving behavior in the clinical and experimental amphetamine (model) psychosis, 1088–1093, Oct 1973
El-Yousef MK: see Janowsky DS, jt au
El-Yousef MK, Janowsky DS, Davis JM, Sekerke HJ: Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, 141–145, Feb 1973
Engel GL: reply to NQ Brill, JS Eaton Jr, KE Godfrey, AE Penetrante, A Werner, RT London, JC Beck, B Liptzin, HM Voth, M Braun, JA Kindwall, JL Mathis, KH Gruberg, AR Sorvino, B Kuhner, The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), 226–227, Feb 1973
Ervin FR: see Climent CE, jt au
Evenson RC: see Sletten IW, jt au
Evenson RC, Altman H, Sletten IW, Knowles RR: Factors in the description and grouping of alcoholics, 49–53, Jan 1973
Ewing JA: see Rouse BA, jt au
Ewing JA, Rouse BA: Therapeutic abortion and a prior psychiatric history, 37–40, Jan 1973
Exner JE Jr: see Murillo LG, jt au

Fabian JJ, Maloney MP, Ward MP: Self-destructive and suicidal behaviors in a neuropsychiatric inpatient facility, 1383–1385, Dec 1973
Fajans P: see Kupfer DJ, jt au
Fann WE: see Janowsky DS, jt au
Fann WE, Davis JM, Wilson IC: Methylphenidate in tardive dyskinesia, 922–924, Aug 1973
Farkas H: Therapeutic spiritual experiences (Ltr to Ed), 1045–1046, Sept 1973
Farnsworth DL: Book Review of RA Altman, CM Byerly (eds): The Public Challenge and the Campus Response, 114, Jan 1973
Fauntleroy A: see Reckless J, jt au
Favazza AR: Marijuana flashbacks (Ltr to Ed), 1399, Dec 1973
Feighner A: see Furman S, jt au
Feinsilver DB: see Friedman RJ, jt au
Feldshuh B, Sillen J, Parker B, Frosch W: The nonpsychotic organic brain syndrome, 1026–1029, Sept 1973
Felix RH: Lawrence Kolb, 1881–1972 (In Mem), 718–719, June 1973
Fellner CH: see Ganser L, jt au
Fersch E: see Rolde EJ, jt au
Fierman LB: Book Review of AO Di Loreto: Comparative Psychotherapy: An Experimental Analysis, 229, Feb 1973
Fieve RR: see Mendlewicz J, jt au
Fieve RR: see Stallone F, jt au
Fieve RR, Meltzer H, Dunner DL, Levitt M, Mendlewicz J, Thomas A: Rubidium: biochemical, behavioral, and metabolic studies in humans, 55–61, Jan 1973
Fieve RR, Mendlewicz J, Fleiss JL: Manic-depressive illness: linkage with the Xg blood group, 1355–1359, Dec 1973
Fiman BG, Conner DR, Segal AC: A comprehensive alcoholism program in the Army, 532–535, May 1973
Finch SM: Book Review of PA Dewald: The Psychoanalytic Process: A Case Illustration, 231–232, Feb 1973
Finch SM: Book Review of R Fliess: Symbol, Dream, and Psychosis, 1169, Oct 1973
Finch SM: Book Review of BN Wixen: Children of the Rich, 1051, Sept 1973
Finch SM: The current status of child psychiatry (Editorial), 799–800, July 1973
Fine PM: Book Review of VL Kahan: Mental Illness in Childhood: A Study of Residential Treatment, 235, Feb 1973
Fine PM: reply to DB Rinsley, Residential treatment: should it be concomitant with family therapy? (Ltr to Ed), 721, June 1973
Finney JC, Skeeters DE, Auvenshine CD, Smith DF: Phases of psychopathology after assassination, 1379–1380, Dec 1973
Fisher S: Book Review of JE Orme, FG Spear: Psychology in Medicine, 614, May 1973
Fitzgibbons DJ, Hokanson DT: The diagnostic decision-making process: factors influencing diagnosis and changes in diagnosis, 972–975, Sept 1973
Flamer R: see Liebson I, jt au
Fleck S: Book Review of JG Howells: Theory and Practice of Family Psychiatry, 614–615, May 1973
Fleeson BR: Book Review of E Katz (ed): Mental Health Services for the Mentally Retarded, 833, July 1973
Fleiss JL: see Fieve RR, jt au
Flynn WR: Book Review of B Garber: Follow-up Study of Hospitalized Adolescents, 829–830, July 1973
Forrest JN Jr: see Levy ST, jt au
Foster T: see Scanlan JM, jt au
Fox K: see Weissman M, jt au
Fox RA: see Gottschalk LA, jt au
Frank LM: Book Review of A Bry: Inside Psychotherapy, 117, Jan 1973
Frank S: see Rolde EJ, jt au
Frantz AG: see Sachar EJ, jt au
Fras I: Book Review of WC Langer: The Mind of Adolf Hitler: The Secret Wartime Report, 499, April 1973
Frazier CA: Request for contributors (Ltr to Ed), 330, Mar 1973
Frazier CA: Request for writers (Ltr to Ed), 111, Jan 1973
Freedman AM: Response to the Presidential Address, 748–749, July 1973
Freyhan FA: Book Review of HE Ehrhardt: 130 Jahre: Deutsche Geselschaft für Psychiatrie und Nervenheilkunde, 945, Aug 1973
Fried FE, Doherty EG, Coyne L: Psychiatric residents: a survey of training needs, satisfactions, and social attitudes, 1342–1345, Dec 1973
Friedman CM: Making abortion consultation therapeutic, 1257–1261, Nov 1973
Friedman JH: discussion of RJ Nathan, The psychiatric treatment of the geriatric patient, 713–714, June 1973
Friedman RJ, Gunderson JG, Feinsilver DB: The psychotherapy of schizophrenia: an NIMH program, 674–677, June 1973
Frosch W: see Feldshuh B, jt au
Frosch WA: Book Review of MS Tarshis: The LSD Controversy: An Overview, 1408, Dec 1973
Fuller M: see Kardener SH, jt au
Furman S, Feighner A: Video feedback in treating hyperkinetic children: a preliminary report, 792–796, July 1973

Galdston I: Book Review of JP Cole: The Problematic Self in Kierkegaard and Freud, 1049–1050, Sept 1973
Ganser L, Holland B, Smith e Incas J, Shervington W, Steinberg JS, Fellner CH: discussion of MH Miller, F Workneh, EB Brody, DJ Lewis, T-y Lin, Foreign medical graduates: a symposium, 441, April 1973
Garber N: Pediatric-child psychiatry collaboration in a health maintenance organization, 1227–1231, Nov 1973
Garber RS: The Council on Professions and Associations (Off Acts), 516–518, April 1973
Gardner JS: see Ryback RS, jt au
Gardos G: The need for feedback to authors (Ltr to Ed), 824–825, July 1973
Garetz FK, Anderson RW: Patterns of professional activities of psychiatrists: a follow-up of 100 psychiatric residents, 981–984, Sept 1973

Garnett RW Jr: Book Review of HG Whittington: Clinical Practice in Community Mental Health Centers, 1407–1408, Dec 1973
Garrard JN: see Cline DW, jt au
Gaztanaga P: see SanGiovanni F, jt au
Gershon S: see Sathananthan GL, jt au
Gerstle ML: Prevalent sexual misconceptions (Ltr to Ed), 1403, Dec 1973
Gesenway DB: Emotional involvement in psychotherapy (Ltr to Ed), 937–938, Aug 1973
Gianturco D: see Hawkins DM, jt au
Gibson RW: The effect of financing on psychiatric care, 299–301, Mar 1973
Gibson RW: Highlights of the 126th annual meeting (Off Acts), 837–839, July 1973
Gibson RW: Report of the Secretary: summary of meetings of Board of Trustees and Executive Committee, May 1972–May 1973 (Off Acts), 1177–1183, Oct 1973
Gillman RD: Book Review of H Parens, LJ Saul: Dependence in Man: A Psychoanalytic Study, 724, June 1973
Giora Z: reply to JC Travis, *Journal*'s culpa? (Ltr to Ed), 328, Mar 1973
Gjessing LR: see Perry TL, jt au
Glass GS: discussion of BA Rouse, JA Ewing, Marijuana and other drug use by women college students: associated risk taking and coping activities, 490–491, April 1973
Glassman AH, Hurwic MJ, Perel JM: Plasma binding of imipramine and clinical outcome, 1367–1369, Dec 1973
Glick ID: see Langee H, jt au
Godfrey KE: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 223–224, Feb 1973
Gold R: see Stoller RJ, jt au
Goldsmith W: Self-enucleation: further views (Ltr to Ed), 329, Mar 1973
Goldstein RL: "The fitness factory," part I: the psychiatrist's role in determining competency, 1144–1147, Oct 1973
Goodell H: see Loranger AW, jt au
Goodwin D: see Zalcman S, jt au
Goodwin FK: see Kotin J, jt au
Goodwin FK: see Murphy DL, jt au
Goodwin FK: see Post RM, jt au
Goodwin FK, Post RM, Dunner DL, Gordon EK: Cerebrospinal fluid amine metabolites in affective illness: the probenecid technique, 73–79, Jan 1973
Gordon EK: see Goodwin FK, jt au
Gordon EK: see Post RM, jt au
Gordon RE, Bielen L, Watts A: Psychiatric screening with automated multiphasic health testing in the VA admission procedure, 46–48, Jan 1973
Gorney R: see Bernard V, jt au
Gottheil E, Alterman AI, Skoloda TE, Murphy BF: Alcoholics' patterns of controlled drinking, 418–422, April 1973
Gottschalk LA, Fox RA, Bates DE: A study of prediction and outcome in a mental health crisis clinic, 1107–1111, Oct 1973
Goulding ME: see Drye RC, jt au
Goulding RL: see Drye RC, jt au
Grasberger JC: see Dohan FC, jt au
Gray W: Ludwig von Bertalanffy, 1901–1972 (In Mem), 1292, Nov 1973
Green R: A brief comment on human sexuality (Ltr to Ed), 110, Jan 1973
Green R: see Stoller RJ, jt au
Greenbaum H: Marriage, family, and parenthood, 1262–1265, Nov 1973
Greenberg LM, Deem MA, McMahon S: reply to DJ Safer, RP Allen, Drug comparison in hyperactive children (Ltr to Ed), 939–940, Aug 1973
Greenberg RP, Davis G, Massey R: The psychological evaluation of patients for a kidney transplant and hemodialysis program, 274–277, Mar 1973
Greenberg RP, Davis G, Massey R: reply to J Yager and to NB Levy, Intellectual impairment in uremic patients (Ltrs to Ed), 1160–1161, Oct 1973
Greene BL: Book Review of HL Silverman (ed): Marital Therapy: Moral, Sociological and Psychological Factors, 616, May 1973
Greiff BS: Book Review of H Levinson: Organizational Diagnosis, 1168–1169, Oct 1973
Greist JH, Gustafson DH, Stauss FF, Rowse GL, Laughren TP, Chiles JA: A computer interview for suicide-risk prediction, 1327–1332, Dec 1973
Grinker RR Sr: Book Review of NG Hale Jr: Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876–1917, 500–501, April 1973
Grinker RR Sr: reply to P Rubinton, Freud and the Americans (Ltr to Ed), 1044, Sept 1973
Grinker RR Sr: see Schimel JL, jt au
Grinspoon L: see Bernard V, jt au
Grobman J: see Morrison AP, jt au
Grossman WK, Karmiol E: Group psychotherapy supervision and its effect on resident training, 920–921, Aug 1973
Gruberg KH: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 226, Feb 1973
Grumet R: No-suicide decisions: a procedural rule (Ltr to Ed), 1163, Oct 1973
Guberman M: see Rolde EJ, jt au
Guiora AZ, Harrison SI: What is psychiatry? a new model of service and education, 1275–1277, Nov 1973
Gunderson EJ: Viet Nam: the Board of Trustees steps out of bounds (Ltr to Ed), 610, May 1973
Gunderson JG: Controversies about the psychotherapy of schizophrenia, 677–681, June 1973
Gunderson JG: see Friedman RJ, jt au
Gustafson DH: see Greist JH, jt au
Guze SB: Hereditary transmission of psychiatric illness (Editorial), 1377–1378, Dec 1973

Halpern AL: Book Review of B Ennis: Prisoners of Psychiatry: Mental Patients, Psychiatrists and the Law, 725–726, June 1973
Hamid TA, Wertz WJ: Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, 689–692, June 1973
Hammerschlag CA, Alderfer CP, Berg D: Indian education: a human systems analysis, 1098–1102, Oct 1973
Hammett VBO: see Adler HM, jt au
Hampton PT, Vogel DB: Personality characteristics of servicemen returned from Viet Nam identified as heroin abusers, 1031–1032, Sept 1973
Handler J: see Bernard V, jt au
Handler L, Perlman G: The attitudes of patients and aides toward the role of the psychiatric aide, 322–325, Mar 1973
Hansen MJ: see McDermott JF Jr, jt au
Hansen S: see Perry TL, jt au
Harlow HF: see Young LD, jt au
Harper EO: The Council on Mental Health Services (Off Acts), 510–511, April 1973
Harrison SI: see Guiora AZ, jt au
Harrow M: see Reilly FE, jt au
Harrow M: see Tucker GJ, jt au
Haslam MT: A case of Capgras syndrome, 493–494, April 1973
Hawkins D: see Reckless J, jt au
Hawkins DM, Norton CB, Eisdorfer C, Gianturco D: Group process research: a factor analytical study, 916–919, Aug 1973
Headlee R: Book Review of H Kohut: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders, 1171–1172, Oct 1973
Hemmings S: see Perry TL, jt au
Hempel WV: Sexual freedom in adolescents: a reaction formation? (Ltr to Ed), 722, June 1973
Heninger GR: see Levy ST, jt au
Henry CE: Book Review of KA Kooi: Fundamentals of Electroencephalography, 1050–1051, Sept 1973
Henry GM, Weingartner H, Murphy DL: Influence of affective states and psychoactive drugs on verbal learning and memory, 966–971, Sept 1973
Hesselbach CF: Id-ego: synergy or antagonism? (Ltr to Ed), 1296–1297, Nov 1973
Hilliard IM: see Scanlan JM, jt au
Hitchcock J: Book Review of CD DeYoung, M Tower: The Nurse's Role in Community Mental Health Centers, 1053, Sept 1973

Hochman JS, Brill NQ: Chronic marijuana use and psychosocial adaptation, 132–139, Feb 1973
Hoffman B: see Langee H, jt au
Hokanson DT: see Fitzgibbons DJ, jt au
Holden JMC: Book Review of S Cahn: The Treatment of Alcoholics: An Evaluative Study, 1052, Sept 1973
Holland B: see Ganser L, jt au
Hollander L, Karp E: Youth psychopathology and family process research, 814–817, July 1973
Hollister LE: Book Review of GG Nahas: Marihuana—Deceptive Weed, 1407, Dec 1973
Holzman PS: see Dyrud JE, jt au
Horton PC: The mystical experience as a suicide preventive, 294–296, Mar 1973
Houck JH: Book Review of DS Viscott: The Making of a Psychiatrist, 332–333, Mar 1973
Houck JH: reply to H Altman, Female patients: intractable or victims of chauvinism? (Ltr to Ed), 495–496, April 1973
Hudgens RW: Mental health of political candidates: notes on Abraham Lincoln (Ltr to Ed), 110, Jan 1973
Hunt WA: Book Review of J Brožek, DI Slobin (eds): Psychology in the USSR: An Historical Perspective, 832–833, July 1973
Hunt WA: Book Review of B Maher (ed): Contemporary Abnormal Psychology: Selected Readings, 1406–1407, Dec 1973
Hurwic MJ: see Glassman AH, jt au
Hussain MZ, Chaudhry ZA: Single versus divided daily dose of trimipramine in the treatment of depressive illness, 1142–1144, Oct 1973

Ianzito BM: see Monnelly EP, jt au
Impastato DJ: Drug dosage in ECT (Ltr to Ed), 1293–1294, Nov 1973
Ingwell RH: Testing for mental retardation: comments on standard deviations (Ltr to Ed), 496, April 1973

Janowsky DS: see El-Yousef MK, jt au
Janowsky DS, El-Yousef MK, Davis JM, Fann WE: Antagonism of guanethidine by chlorpromazine, 808–812, July 1973
Janowsky DS, El-Yousef MK, Davis JM, Sekerke HJ: Antagonistic effects of physostigmine and methylphenidate in man, 1370–1376, Dec 1973
Janus S, Bess B: Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, 187–191, Feb 1973
Johnson AC, Kulkarni AS: Piperacetazine and chlorpromazine: a comparison, 603–605, May 1973
Johnson JC Jr: Report of the Speaker (Off Acts), 1189–1190, Oct 1973
Johnson WC: Statements about Viet Nam: APA's role (Ltr to Ed), 722, June 1973
Johnston N: see Cooke G, jt au
Jones M: see Aledort SL, jt au
Jones RE: Benjamin Rush: morality in government (Editorial), 1137–1138, Oct 1973
Jorgensen PA: see Ryback WS, jt au
Jorgensen SE: see Ryback WS, jt au
Joyce SA: see Hankoff LD, jt au
Jus A: Social systems and the criteria of health as defined by the World Health Organization, 125–131, Feb 1973

Kal EF: Contradictions in the alcoholism criteria (Ltr to Ed), 606, May 1973
Kalda R: Chlorpromazine contraindicated in delirium tremens (Ltr to Ed), 1042, Sept 1973
Kalinowsky LB: Book Review of MO Strahl, NDC Lewis (eds): Differential Diagnosis in Clinical Psychiatry: The Lectures of Paul H. Hoch, M.D., 1298, Nov 1973
Kane FJ Jr: Book Review of WC Schutz: Here Comes Everybody: Bodymind and Encounter Culture, 1052–1053, Sept 1973
Kane FJ Jr, Lachenbruch PA, Lipton MA, Baram D: Motivational factors in abortion patients, 290–293, Mar 1973
Kaplan HA: see McGarry AL, jt au
Kardener SH, Fuller M, Mensh IN: A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients, 1077–1081, Oct 1973
Karmiol E: see Grossman WK, jt au
Karp E: see Hollander L, jt au
Kase HM: Dumping of patients: funding and statistics a problem (Ltr to Ed), 111, Jan 1973
Kazamatsuri H, Chien C-p, Cole JO: Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, 479–483, April 1973
Keating GW, Brown WA, Standley K: The volunteer rescue squad: the impact of a group on the psychological adaptation of its members, 278–282, Mar 1973
Keller WK: Book Review of CJ Bridge: Alcoholism and Driving, 1409, Dec 1973
Kellner R, Sheffield BF: The one-week prevalence of symptoms in neurotic patients and normals, 102–105, Jan 1973
Kelly FJ: see Rolde EJ, jt au
Kelly WA Jr: Suicide and psychiatric education, 463–468, April 1973
Kernberg OF: discussion of G Adler, Hospital treatment of borderline patients, 35–36, Jan 1973
Kesselman M: see Marcos LR, jt au
Kiev A: Book Review of WP Lebra (ed): Transcultural Research in Mental Health, vol III of Mental Health Research in Asia and the Pacific, 1301–1302, Nov 1973
Kilgore T: see Thomsen WK, jt au
Kim K-i: see Chang SC, jt au
Kindler AR: see Pederson AM, jt au
Kindwall JA: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 225, Feb 1973
Kinzie JD, Bolton JM: Psychiatry with the aborigines of West Malaysia, 769–773, July 1973
Kirilcuk V: see Arnold LE, jt au
Kirsch TB: Book Review of J Singer: Boundaries of the Soul, 830, July 1973
Klawans HL Jr: The pharmacology of tardive dyskinesias, 82–86, Jan 1973
Klein DF: see Rifkin A, jt au
Klemperer E: The safety of hypnoses (Ltr to Ed), 1044–1045, Sept 1973
Klerman GL: see Weissman M, jt au
Kline FM: How success nearly wrecked a residency experience, 1038–1040, Sept 1973
Knight F: see Beaubrun MH, jt au
Knight SW: see Donlon PT, jt au
Knott JR: see Travis TA, jt au
Knowles RR: see Evenson RC, jt au
Kolb LC: The Council on National Affairs (Off Acts), 513–514, April 1973
Kondo CY: see Travis TA, jt au
Koral J: see Kupfer DJ, jt au
Koson D, Robey A: Amnesia and competency to stand trail, 588–591, May 1973
Kotin J: see Post RM, jt au
Kotin J, Post RM, Goodwin FK: Drug treatment of depressed patients referred for hospitalization, 1139–1141, Oct 1973
Kozel NJ: see Brown BS, jt au
Kramer S: Methaqualone as aphrodisiac (Ltr to Ed), 1044, Sept 1973
Kreps JM: Modern man and his instinct of workmanship, 179–183, Feb 1973
Kroger WS: Acupunctural analgesia: its explanation by conditioning theory, autogenic training, and hypnosis, 855–860, Aug 1973
Kuhner B: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 226, Feb 1973
Kulkarni AS: see Johnson AC, jt au
Kupfer DJ: see Weiss BL, jt au
Kupfer DJ, Detre T, Koral J, Fajans P: A comment on the "amotivational syndrome" in marijuana smokers, 1319–1322, Dec 1973
Kurtin SB: see Rifkin SA, jt au

Lachenbruch PA: see Kane FJ Jr, jt au
Landau S: see Werkman SL, jt au
Langee H, Glick ID, Hoffman B, Silver LB, Morrison AP: The requirements of a psychiatric residency training program circa 1972, 1151–1152, Oct 1973

Langrod J: see Lowinson J, jt au
Langsley DG: Peer review: prospects and problems, 301–304, Mar 1973
Lassers E, Nordan R, Bladholm S: Steps in the return to school of children with school phobia, 265–268, Mar 1973
Laub D: see Brenneis CB, jt au
Laughlin HP: Book Review of M Levine: Psychiatry and Ethics, 1164, Oct 1973
Laughren TP: see Greist JH, jt au
Lazerson AM: Psychiatry residents as college teachers: an evaluation of a training for teaching program, 658–662, June 1973
Lebensohn ZM: Bernard Glueck, Sr, 1884–1972 (In Mem), 326, Mar 1973
Lebensohn ZM: Empty hospital beds and human misery (Ltr to Ed), 1401, Dec 1973
Lee JE: see Loranger AW, jt au
Lemere F: Book Review of Alcohol and Health. Report from the Secretary of Health, Education, and Welfare, 1165–1166, Oct 1973
Lemere F: Book Review of Y Israel, J Mardones (eds): Biological Basis of Alcoholism, 1049, Sept 1973
Lemere F: Book Review of DC McClelland, WN Davis, R Kalin, E Wanner: The Drinking Man, 231, Feb 1973
Lemere F, Smith JW: Alcohol-induced sexual impotence, 212–213, Feb 1973
Leon RL: Book Review of J Lieb, II Lipsitch, AE Slaby: The Crisis Team: A Handbook for the Mental Health Professional, 944–945, Aug 1973
Lester D: Basic research and suicide prevention (Ltr to Ed), 1402–1403, Dec 1973
Levenson AI: see Beigel A, jt au
Levinson P: Religious delusions in counter-culture patients, 1265–1269, Nov 1973
Levitt M: see Fieve RR, jt au
Levy A: see Vaughan WT Jr, jt au
Levy NB: Intellectual impairment in uremic patients (Ltr to Ed), 1160, Oct 1973
Levy ST, Forrest JN Jr, Heninger GR: Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, 1014–1018, Sept 1973
Lewis AB Jr: discussion of FE Reilly, M Harrow, GJ Tucker, Language and thought content in acute psychosis, 416–417, April 1973
Lewis DJ: see Miller MH, jt au
Lewis HA: Measuring responses during treatment (Ltr to Ed), 1403, Dec 1973
Liberman RP: see Wolpe J, jt au
Liebson I, Bigelow G, Flamer R: Alcoholism among methadone patients: a specific treatment method, 483–485, April 1973
Lin T-y: see Miller MH, jt au
Linn L: Psychiatric factors in security screening, 648–652, June 1973
Lion JR, Pasternak SA: Countertransference reactions to violent patients, 207–210, Feb 1973
Lipper S: Educating the scientist-physician (Ltr to Ed), 1402, Dec 1973
Lipsius LH: The Weed system and psychiatry (Ltr to Ed), 610–611, May 1973
Lipsius SH: Judgments of alternatives to hospitalization, 892–895, Aug 1973
Lipton MA: see Kane FJ Jr, jt au
Liptzin B: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 224–225, Feb 1973
Liskow B: see Zalcman S, jt au
Loeb FF Jr: see Loeb LR, jt au
Loeb LR, Peal S, Loeb FF Jr, Templeton B: Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, 160–164, Feb 1973
Loesch J: see Thurnblad RJ, jt au
London RT: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 224, Feb 1973
Loranger AW, Goodell H, McDowell FH, Lee JE, Sweet RD: Parkinsonism, L-dopa, and intelligence, 1386–1389, Dec 1973
Lowinson J, Langrod J, Alperin L: Legal services as a tool in treating the addict, 592–595, May 1973
Luby ED: Book Review of JH Masserman (ed): Science and Psychoanalysis, vol XIX: Dream Dynamics, 616–617, May 1973
Lurie HJ: see Barber WH, jt au

MacKenzie KR: The eclectic approach to the treatment of phobias, 1103–1106, Oct 1973
Maguigad LC: discussion of D Koson, A Robey, Amnesia and competency to stand trial, 591–592, May 1973
Malcolm M: Assessing self-assessment (Ltr to Ed), 1161, Oct 1973
Maloney MP: see Fabian JJ, jt au
Mandell AJ: Western humanism, modern liberal politics, and psychiatric training: friends or foes? 529–531, May 1973
Manheimer DI, Davidson ST, Balter MB, Mellinger GD, Cisin IH, Parry HJ: Popular attitudes and beliefs about tranquilizers, 1246–1253, Nov 1973
Marcos LR, Alpert M, Urcuyo L, Kesselman M: The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients, 549–553, May 1973
Marcus SI: see Talbott JA, jt au
Marini JL: Book Review of FC Brown: Hallucinogenic Drugs, 1304, Nov 1973
Markoff RA: see McDermott JF Jr, jt au
Marmor J: Book Review of J Frosch, N Ross (eds): The Annual Survey of Psychoanalysis, vol 10: A Comprehensive Survey of Current Psychoanalytic Theory and Practice, 116–117, Jan 1973
Marmor J: The future of psychoanalytic therapy, 1197–1202, Nov 1973
Marmor J: see Bernard V, jt au
Marmor J: see Stoller RJ, jt au
Marohn RC, Dalle-Molle D, Offer D, Ostrov E: A hospital riot: its determinants and implications for treatment, 631–636, June 1973
Martin M: Book Review of JR Lion: Evaluation and Management of the Violent Patient: Guidelines in the Hospital and Institution, 1166, Oct 1973
Marty S: see Vaughan WT Jr, jt au
Masserman JH: Review reviewed (Ltr to Ed), 327, Mar 1973
Massey R: see Greenberg RP, jt au
Mathis JL: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 225, Feb 1973
Maxmen JS: see Tucker GJ, jt au
Mayerovitch J: see Sigal JJ, jt au
McDermott JF Jr, Bolman WM, Arensdorf AM, Markoff RA: The concept of child advocacy, 1203–1206, Nov 1973
McDermott JF Jr, Char WF, Hansen MJ: Motivation for medicine in the seventies, 252–256, Mar 1973
McDowell FH: see Loranger AW, jt au
McGarry AL, Kaplan HA: Current trends in mental health law, 621–630, June 1973
McGinnis NH: see Schwab JJ, jt au
McKinney WT Jr: see Young LD, jt au
McKnew DH Jr, Cytryn L: Historical background in children with affective disorders, 1278–1280, Nov 1973
McMahon S: see Greenberg LM, jt au
McNamara JR: The clinical case conference reconsidered, 1153–1154, Oct 1973
McPartland RJ: see Weiss BL, jt au
Mellinger GD: see Manheimer DI, jt au
Mellsop G, Whittingham S: Antinuclear factor: age and sex (Ltr to Ed), 609, May 1973
Meltzer H: see Fieve RR, jt au
Meltzer HY: Book Review of SH Snyder (ed): Perspectives in Neuropharmacology: A Tribute to Julius Axelrod, 612, May 1973
Mendels J, DiGiacomo J: The treatment of depression with a single daily dose of imipramine pamoate, 1022–1024, Sept 1973
Mendlewicz J: see Fieve RR, jt au
Mendlewicz J: see Stallone F, jt au
Mendlewicz J, Fieve RR, Stallone F: Relationship between the effectiveness of lithium therapy and family history, 1011–1013, Sept 1973
Menninger R: see Bernard V, jt au
Menolascino FJ: Book Review of FF de la Cruz, GD LaVeck (eds): Human Sexuality and the Mentally Retarded, 1171, Oct 1973
Mensh IN: see Kardener SH, jt au
Messner E: Political psychiatry: the psychiatrist in elective public office, 283–285, Mar 1973
Meyers AL: see Nace EP, jt au

Meyers MB: see Brown BS, jt au
Miller D: see Rossman PG, jt au
Miller MH: Book Review of TA Harris: I'm OK—You're OK: A Practical Guide to Transactional Analysis, 1173–1174, Oct 1973
Miller MH, Auerbach J: Is psychiatry as establishment an effective force? 761–764, July 1973
Miller MH, Workneh F, Brody EB, Lewis DJ, Lin T-y: Foreign medical graduates: a symposium, 435–441, April 1973
Minkoff K, Bergman E, Beck AT, Beck R: Hopelessness, depression, and attempted suicide, 455–459, April 1973
Mischorr MT: see Hankoff LD, jt au
Molish HB: Book Review of RS McCully: Rorschach Theory and Symbolism: A Jungian Approach to Clinical Material, 1304–1305, Nov 1973
Monnelly EP, Ianzito BM, Stewart MA: Psychiatric consultations in a children's hospital, 789–790, July 1973
Monroe RR: The Council on Research and Development (Off Acts), 512–513, April 1973
Mora G: Book Review of J de Ajuriaguerra: Manuel de Psychiatrie de l'Enfant, 1300, Nov 1973
Mora G: 1973 anniversaries, 1346–1350, Dec 1973
Morris HH Jr: see Appel KE, jt au
Morrison AP: see Langee H, jt au
Morrison AP, Shore MF, Grobman J: On the stresses of community psychiatry, and helping residents to survive them, 1237–1241, Nov 1973
Morrison JR, Stewart MA: Evidence for polygenetic inheritance in the hyperactive child syndrome, 791–792, July 1973
Moskowitz JA: Communicative meaning in Capgras syndrome (Ltr to Ed), 1297, Nov 1973
Mulder DW: Book Review of R Bannister (reviser): Brain's Clinical Neurology, 4th ed, 1409, Dec 1973
Mulder DW: Book Review of WB Matthews, H Miller: Diseases of the Nervous System, 832, July 1973
Murillo LG, Exner JE Jr: The effects of regressive ECT with process schizophrenics, 269–273, Mar 1973
Murillo LG, Exner JE Jr: reply to J Spensley, Ataractic drugs versus ECT in schizophrenia (Ltr to Ed), 1162–1163, Oct 1973
Murphy BF: see Gottheil E, jt au
Murphy DL: see Henry GM, jt au
Murphy DL, Goodwin FK, Brodie HKH, Bunney WE Jr: L-dopa, dopamine, and hypomania, 79–82, Jan 1973
Murphy GE: Suicide and the right to die (Editorial), 472–473, April 1973
Muslin H: see Thurnblad RJ, jt au
Myers JM: If they were here now (Editorial), 910–911, Aug 1973

Nace EP, Meyers AL, Rothberg JM: Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, 1242–1245, Nov 1973
Nadelson CC: see Notman MT, jt au
Naftulin DH: "Credentials consciousness": stimulus for continuing education and peer review in psychiatry, 653–657, June 1973
Nagler B: Book Review of J Wortis (ed): Mental Retardation, An Annual Review: III, 1305, Nov 1973
Nathan RJ: The psychiatric treatment of the geriatric patient, 711–713, June 1973
Nelson LM: see Ellinwood EH Jr, jt au
Newbold HL: Assessing self-assessment (Ltr to Ed), 1161–1162, Oct 1973
Newman DE: see Vaughan WT Jr, jt au
Nir Y, Cutler R: The therapeutic utilization of the juvenile court, 1112–1117, Oct 1973
Nordan R: see Lassers E, jt au
Norton CB: see Hawkins DM, jt au
Notman MT, Nadelson CC: Medicine: a career conflict for women, 1123–1126, Oct 1973
Noyes R Jr: Book Review of AD Weisman: On Dying and Denying: A Psychiatric Study of Terminality, 1298–1299, Nov 1973

Ochberg FM: Book Review of Television and Growing Up: The Impact of Televised Violence. Report to the Surgeon General, 943, Aug 1973
Offer D: see Marohn RC, jt au
Olinick SL: Book Review of KR Eissler: Talent and Genius: The Fictitious Case of Tausk Contra Freud, 1302–1303, Nov 1973
Orgun IN: Playroom setting for diagnostic family interviews, 540–542, May 1973
Ostow M: Book Review of WO Evans, NS Kline (compilers and eds): Psychotropic Drugs in the Year 2000: Use by Normal Humans, 617, May 1973
Ostow M: reply to R Seidenberg and to N Simon, Speaking out on Jewish young people (Ltrs to Ed), 607–608, May 1973
Ostrov E: see Marohn RC, jt au
Ottenberg P: see Bernard V, jt au
Ozarin LD: Book Review of HG Whittington (ed): Development of an Urban Mental Health Center, 1173, Oct 1973

Panzetta AF, Sloane RB, Aronson H: A survey of attitudes of chairmen of departments of psychiatry toward community mental health, 175–178, Feb 1973
Parker B: see Feldshuh B, jt au
Parry HJ: see Manheimer DI, jt au
Parsons LB: see Walker WR, jt au
Pasamanick B: On "maturational lag" (Ltr to Ed), 1398, Dec 1973
Pasternak SA: see Lion JR, jt au
Patterson CD: see Callan JP, jt au
Patterson PH: see U'Ren RC, jt au
Paul NL: Book Review of A Ferber, M Mendelsohn, A Napier: The Book of Family Therapy, 830–831, July 1973
Peal S: see Loeb LR, jt au
Pederson AM, Awad GA, Kindler AR: Epidemiological differences between white and nonwhite suicide attempters, 1071–1076, Oct 1973
Peele R, Von Loetzen IS: Phenothiazine deaths: a critical review, 306–309, Mar 1973
Penetrante AE: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 224, Feb 1973
Perel JM: see Glassman AH, jt au
Perlman G: see Handler L, jt au
Perr IN: Book Review of J Zusman, DL Davidson (eds): Organizing the Community to Prevent Suicide, 116, Jan 1973
Perry TL, Hemmings S, Drummond GI, Hansen S, Gjessing LR: Urinary cyclic AMP in periodic catatonia, 927–929, Aug 1973
Pinsker H: see Richman A, jt au
Pinsker H: see Shapiro ET, jt au
Plutchik R: see Climent CE, jt au
Pogany E: see Cooke G, jt au
Pokorny AD: Eugen Kahn, 1887–1972 (In Mem), 822, July 1973
Pollin W: see Wyatt RJ, jt au
Post RM: see Goodwin FK, jt au
Post RM: see Kotin J, jt au
Post RM, Kotin J, Goodwin FK, Gordon EK: Psychomotor activity and cerebrospinal fluid amine metabolites in affective illness, 67–72, Jan 1973
Press M: see Brown D, jt au
Prince B: see Thomsen WK, jt au
Prince RM Jr, Ackerman RE, Barksdale BS: Collaborative provision of aftercare services, 930–932, Aug 1973
Pruyser PW: Book Review of AH Kutscher, LG Kutscher (eds): Religion and Bereavement: Counsel for the Physician, Advice for the Bereaved, Thoughts for the Clergyman, 502–503, April 1973

Quinlan D: see Tucker GJ, jt au
Quitkin F: see Rifkin A, jt au

Rada RT: see Donlon PT, jt au
Rahe RH, Bennett L, Romo M, Siltanen P, Arthur RJ: Subjects' recent life changes and coronary heart disease in Finland, 1222–1226, Nov 1973
Rainer JD: Book Review of G Claridge, S Canter, WI Hume: Personality Differences and Biological Variations: A Study of Twins, 1299, Nov 1973

Rainer JD: Book Review of T Dobzhansky: Genetic Diversity and Human Equality, 1169–1170, Oct 1973
Rainer JD: Book Review of AR Kaplan (ed): Genetic Factors in "Schizophrenia," 113–114, Jan 1973
Rappeport JR: Book Review of J Katz, AM Capron, ES Glass: Experimentation with Human Beings: The Authority of the Investigator, Subject, Professions, and State in the Human Experimentation Process, 228–229, Feb 1973
Raskin DE: Participatory management in psychiatry, 219–221, Feb 1973
Ratnavale DN: Psychiatry in Shanghai, China: observations in 1973, 1082–1087, Oct 1973
Ravel J-L: see Beiser M, jt au
Reckless J, Hawkins D, Fauntleroy A: Time-extended group therapy sessions in a remote setting, 1024–1026, Sept 1973
Reich R: Care of the chronically mentally ill—a national disgrace (Editorial), 911–912, Aug 1973
Reich W: Activist and traditionalist approaches in psychiatry (Ltr to Ed), 825, July 1973
Reilly FE, Harrow M, Tucker GJ: Language and thought content in acute psychosis, 411–416, April 1973
Reiser MF: Psychiatry in the undergraduate medical curriculum, 565–567, May 1973
Renner JA, Rubin ML: Engaging heroin addicts in treatment, 976–980, Sept 1973
Resnik HLP, Davison WT, Schuyler D, Christopher P: Videotape confrontation after attempted suicide, 460–463, April 1973
Revitch E: Lobotomies defended (Ltr to Ed), 608, May 1973
Rexford EN: Book Review of RM Glasscote, ME Fishman, M Sonis: Children and Mental Health Centers: Programs, Problems, and Prospects, 827–828, July 1973
Rhoads JM: discussion of L Solyom, R Shugar, S Bryntwick, C Solyom, Treatment of fear of flying, 427, April 1973
Rice DG: see Rice JK, jt au
Rice JK, Rice DG: Implications of the women's liberation movement for psychotherapy, 191–196, Feb 1973
Richman A, Pinsker H: Utilization review of psychiatric inpatient care, 900–903, Aug 1973
Riedel DC: see Tischler GL, jt au
Rifkin A, Kurtin SB, Quitkin F, Klein DF: Lithium-induced folliculitis, 1018–1019, Sept 1973
Rinsley DB: Book Review of JF Masterson: Treatment of the Borderline Adolescent: A Developmental Approach, 228, Feb 1973
Rinsley DB: Residential treatment: should it be concomitant with family therapy? (Ltr to Ed), 721, June 1973
Ripley HS: Book Review of JE Cooper, RE Kendell, BJ Gurland, L Sharpe, JRM Copeland, R Simon: Psychiatric Diagnosis in New York and London: A Comparative Study of Mental Hospital Admissions, 613, May 1973
Ripley HS: Suicidal behavior in Edinburgh and Seattle, 995–1001, Sept 1973
Robbins H: A patient's view of presenile dementia (Ltr to Ed), 1294–1295, Nov 1973
Robey A: see Koson D, jt au
Rodgers T: see Scanlan JM, jt au
Rodgers TC: discussion of JS Hochman, NQ Brill, Chronic marijuana use and psychosocial adaptation, 139–140, Feb 1973
Rodgers TC: reply to CF Hesselbach, Id-ego: synergy or antagonism? (Ltr to Ed), 1297, Nov 1973
Roemer PA: Psychiatrists in the ghetto (Ltr to Ed), 720, June 1973
Roeske NA: Women in psychiatry: past and present areas of concern, 1127–1131, Oct 1973
Rogeness GA, Bednar RA: Teenage helper: a role in community mental health, 933–936, Aug 1973
Rogers GA: Chlorpromazine contraindicated in delirium tremens (Ltr to Ed), 1042–1043, Sept 1973
Rolde EJ, Fersch E, Kelly FJ, Frank S, Guberman M: A law enforcement training program in a mental health center catchment area, 1002–1005, Sept 1973
Rollins A: see Climent CE, jt au
Romano J: The teaching of psychiatry to medical students, 559–562, May 1973
Rome HP: The Council on International Affairs (Off Acts), 516, April 1973
Romo M: see Rahe RH, jt au
Ross AM: see Talbott JA, jt au
Ross M: Book Review of JA Sherman: On the Psychology of Women: A Survey of Empirical Studies, 1300–1301, Nov 1973
Ross M: Suicide and the psychiatrist (Ltr to Ed), 937, Aug 1973
Ross N: Book Review of E Jacobson: Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions, 498, April 1973
Ross WD: Book Review of PC Kuiper: The Neuroses: A Psychoanalytic Survey, 727–728, June 1973
Rossi EL: The dream-protein hypothesis, 1094–1097, Oct 1973
Rossman PG, Miller D: The effects of social prejudice on hospitalized adolescents, 1029–1031, Sept 1973
Rothberg JM: see Nace JP, jt au
Rothstein E: Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, 1381–1382, Dec 1973
Rouse BA: see Ewing JA, jt au
Rouse BA, Ewing JA: Marijuana and other drug use by women college students: associated risk taking and coping activities, 486–490, April 1973
Rouzer DL: see Cline DW, jt au
Rowse GL: see Greist JH, jt au
Roy C: Indian peyotists and alcohol (Ltr to Ed), 329–330, Mar 1973
Rubin ML: see Renner JA, jt au
Rubinton P: Freud and the Americans (Ltr to Ed), 1044, Sept 1973
Ryback RS, Gardner JS: Problem formulation: the problem-oriented record, 312–316, Mar 1973
Ryback WS, Jorgensen PA, Jorgensen SE: Sensitivity reaction to imipramine (Ltr to Ed), 940, Aug 1973
Saavedra JM: see Wyatt RJ, jt au
Sabshin M: see Brodie HKH, jt au
Sachar EJ, Frantz AG, Altman N, Sassin J: Growth hormone and prolactin in unipolar and bipolar depressed patients: responses to hypoglycemia and L-dopa, 1362–1367, Dec 1973
Safer DJ, Allen RP: Drug comparison in hyperactive children (Ltr to Ed), 939, Aug 1973
Salzman L: see Schimel JL, jt au
Salzman L: Truth, honesty, and the therapeutic process, 1280–1282, Nov 1973
SanGiovanni F, Taylor MA, Abrams R, Gaztanaga P: Rapid control of psychotic excitement states with intramuscular haloperidol, 1155–1156, Oct 1973
Sassin J: see Sachar EJ, jt au
Sathananthan GL, Gershon S: Imipramine withdrawal: an akathisia-like syndrome, 1286–1287, Nov 1973
Saul LJ: Book Review of BD Fine, ED Joseph, HF Waldhorn (eds): Recollection and Reconstruction; Reconstruction in Psychoanalysis, 117, Jan 1973
Scanlan JM, Rodgers T, Hilliard IM, Carter WB, Billingsley TH, Foster T, Axelson AA: The funding crisis: an opportunity for growth (Ltr to Ed), 823, July 1973
Scher M: Women psychiatrists in the United States, 1118–1122, Oct 1973
Schildkraut JJ: Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, 695–699, June 1973
Schimel JL, Salzman L, Chodoff P, Grinker RR Sr, Will OA Jr: Changing styles in psychiatric syndromes: a symposium, 146–155, Feb 1973
Schlezinger NS: Book Review of EA Spiegel (ed): Progress in Neurology and Psychiatry: An Annual Review, vol XXVI, 233, Feb 1973
Schnackenberg RC: Caffeine as a substitute for schedule II stimulants in hyperkinetic children, 796–798, July 1973
Schnaper HW: see Schnaper N, jt au
Schnaper N: Book Review of D Hendin: Death as a Fact of Life, 831–832, July 1973
Schnaper N, Schnaper HW: Book Review of RE Neale: The Art of Dying, 1170, Oct 1973
Schneck JM: Book Review of J Haley: Uncommon Therapy, 1303, Nov 1973

Schneck JM: Book Review of A Meares: A System of Medical Hypnosis, 1407, Dec 1973
Schoonmaker JB: Danger of depot phenothiazine treatment in acute psychosis (Ltr to Ed), 722–723, June 1973
Schubert AS: The death of Lyndon B. Johnson (Ltr to Ed), 611, May 1973
Schuyler D: see Resnik HLP, jt au
Schwab JJ, McGinnis NH, Warheit GJ: Social psychiatric impairment: racial comparisons, 183–187, Feb 1973
Sealy JR: see Slaby AE, jt au
Segal AC: see Fiman BG, jt au
Seidenberg R: Speaking out on Jewish young people (Ltr to Ed), 607, May 1973
Seixas FA: reply to EF Kal, Contradictions in the alcoholism criteria (Ltr to Ed), 606, May 1973
Sekerke HJ: see EL-Yousef MK, jt au
Sekerke HJ: see Janowsky DS, jt au
Sell MB: Surgery using hypnosis in 1845 (Ltr to Ed), 1402, Dec 1973
Serber M: see Wolpe J, jt au
Shaffer S: see Zusman J, jt au
Shapiro ET, Pinsker H: Shared ethnic scotoma, 1338–1341, Dec 1973
Sheffield BF: see Kellner R, jt au
Shelley E: see Stallone F, jt au
Shervington W: see Ganser L, jt au
Shore JH, Stone DL: Duodenal ulcer among Northwest coastal Indian women, 774–777, July 1973
Shore MF: see Morrison AP, jt au
Shugar R: see Solyom L, jt au
Siassi I, Thomas M: Physicians and the new sexual freedom, 1256–1257, Nov 1973
Sidley NT, Stolarz FJ: A proposed "dangerous sex offender" law, 765–768, July 1973
Sifneos PE: Book Review of WS Agras (ed): Behavior Modification: Principles and Clinical Applications, 1408, Dec 1973
Sifneos PE: Book Review of I Chien: The Science of Behavior and the Image of Man, 832, July 1973
Sifneos PE: An overview of a psychiatric clinic population, 1033–1035, Sept 1973
Sigal JJ, Chagoya L, Villeneuve C, Mayerovitch J: Later psychosocial sequelae of early childhood illness (severe croup), 786–789, July 1973
Sillen J: see Feldshuh B, jt au
Siltanen P: see Rahe RH, jt au
Silver LB: see Langee H, jt au
Silverman AJ: The Council on Medical Education and Career Development (Off Acts), 507–509, April 1973
Simmons JQ III: Book Review of R Borger, F Cioffi (eds): Explanation in the Behavioral Sciences, 114–115, July 1973
Simon A: Karl Murdock Bowman, 1888–1973 (In Mem), 717–718, June 1973
Simon N: Speaking out on Jewish young people (Ltr to Ed), 607, May 1973
Simonson M: Drug dosage in ECT (Ltr to Ed), 1293, Nov 1973
Simpson GM: see Cooper TB, jt au
Skeeters DE: see Finney JC, jt au
Skelton WD: see Walker WR, jt au
Skerrett AF: see Talbott JA, jt au
Skoloda TE: see Gottheil E, jt au
Slaby AE, Sealy JR: Black liberation, women's liberation, 196–200, Feb 1973
Sletten IW: see Evenson RC, jt au
Sletten IW, Altman H, Evenson RC, Cho DW: Computer assignment of psychotropic drugs, 595–598, May 1973
Sloane RB: see Panzetta AF, jt au
Smith BJ: see Talbott JA, jt au
Smith DF: see Finney JC, jt au
Smith JA: Book Review of CC Brown, C Savage (eds): The Drug Abuse Controversy, 1301, Nov 1973
Smith JA: Book Review of RI Shader (ed): Psychiatric Complications of Medical Drugs, 833, July 1973
Smith JW: see Lemere F, jt au
Smith K: see Bernard V, jt au
Smith e Incas J: see Ganser L, jt au
Snyder SH: Amphetamine psychosis: a "model" schizophrenia mediated by catecholamines, 61–67, Jan 1973
Socarides CW: Book Review of L Ovesey: Homosexuality and Pseudohomosexuality, 334–335, Mar 1973
Socarides CW: see Stoller RJ, jt au
Solomon RZ: Book Review of P Kline: Fact and Fantasy in Freudian Theory, 1172, Oct 1973
Solomon RZ: Book Review of E Pfeiffer (ed): Sigmund Freud and Lou Andreas-Salomé: Letters, 724–725, June 1973
Solomon RZ: Women in psychiatry (Editorial), 1136–1137, Oct 1973
Solyom C: see Solyom L, jt au
Solyom L, Shugar R, Bryntwick S, Solyom C: Treatment of fear of flying, 423–427, April 1973
Sorvino AR: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 226, Feb 1973
Spensley J: Ataractic drugs versus ECT in schizophrenia (Ltr to Ed), 1162, Oct 1973
Spitz HI: Book Review of HI Kaplan, BJ Sadock (eds): Comprehensive Group Psychotherapy, 1404, Dec 1973
Spitzer RL: see Stoller RJ, jt au
Spotnitz H: reply to DB Gesenway, Emotional involvement in psychotherapy (Ltr to Ed), 938–939, Aug 1973
Stabenau JR: Schizophrenia: a family's projective identification, 19–23, Jan 1973
Stabenau JR: see Becker RE, jt au
Stallone F: see Mendlewicz J, jt au
Stallone F, Shelley E, Mendlewicz J, Fieve RR: The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness, 1006–1010, Sept 1973
Standley K: see Keating GW, jt au
Stanton MD: reply to AR Favazza and to FE Anderson, Marijuana flashbacks (Ltrs to Ed), 1399–1400, Dec 1973
Stauss FF: see Greist JH, jt au
Steadman HJ: Follow-up on Baxstrom patients returned to hospitals for the criminally insane, 317–319, Mar 1973
Steinberg JS: see Ganser L, jt au
Stephens RC, Weppner RS: Legal and illegal use of methadone: one year later, 1391–1394, Dec 1973
Stevenson I: Book Review of A MacKenzie: Apparitions and Ghosts: A Modern Study, 115–116, Jan 1973
Stewart MA: see Monnelly EP, jt au
Stewart MA: see Morrison JR, jt au
Stolarz FJ: see Sidley NT, jt au
Stoller RJ: Male transsexualism: uneasiness, 536–539, May 1973
Stoller RJ: Overview: the impact of new advances in sex research on psychoanalytic theory, 241–251, Mar 1973
Stoller RJ, Marmor J, Bieber I, Gold R, Socarides CW, Green R, Spitzer RL: A symposium: should homosexuality be in the APA nomenclature? 1207–1216, Nov 1973
Stone DL: see Shore JH, jt au
Stone SI: Book Review of E Kestemberg, J Kestemberg, S Decobert: La faim et le corps: Une étude psychanalytique de l'anorexie mentale, 1052, Sept 1973
Stotsky BA: see Chien C-p, jt au
Straker N: see Wineburg EN, jt au
Sudilovsky A: see Ellinwood EH Jr, jt au
Suomi SS: see Young LD, jt au
Sweet RD: see Loranger AW, jt au
Sweetland RC: Book Review of AH Maslow: The Farther Reaches of Human Nature, 1303–1304, Nov 1973
Swenson DD: reply to JH Masserman, Review reviewed (Ltr to Ed), 327–328, Mar 1973

Talbott JA, Ross AM, Skerrett AF, Curry MD, Marcus SI, Theodorou H, Smith B: The paraprofessional teaches the professional, 805–808, July 1973
Talkington PC: The Presidential Address: a time for action, 745–747, July 1973
Tanguay PE: Book Review of SI Harrison, JD McDermott (eds): Childhood Psychopathology, 612–613, May 1973
Taylor MA: see SanGiovanni F, jt au
Taylor RL: see Torrey EF, jt au

Tec L: Hyperkinetic children and the Staccato syndrome (Ltr to Ed), 330, Mar 1973
Templeton B: see Loeb LR, jt au
Tennant FS Jr: see Weaver SC, jt au
Theodorou H: see Talbott JA, jt au
Thigpen CH: Succinylcholine in EST (Ltr to Ed), 722, June 1973
Thigpen CH: reply to M Simonson, DF Wehlage, PH Blachly, and DJ Impastato, Drug dosage in ECT (Ltrs to Ed), 1294, Nov 1973
Thomas A: see Fieve RR, jt au
Thomas M: see Siassi I, jt au
Thompson LJ: Learning disabilities: an overview, 393–399, April 1973
Thompson LJ: reply to B Pasamanick, On "maturational lag" (Ltr to Ed), 1398–1399, Dec 1973
Thomsen WK, Prince B, Kilgore T: Compulsive water drinking (Ltr to Ed), 610, May 1973
Thornton BP: see Thornton WE, jt au
Thornton WE, Thornton BP: Tardive dyskinesia and low dosage (Ltr to Ed), 1401, Dec 1973
Thurnblad RJ, Muslin H, Loesch J: A test of clinical learning by medical students, 568–570, May 1973
Tischler GL, Riedel DC: A criterion approach to patient care evaluation, 913–916, Aug 1973
Tolor A: Opinions about mental illness and political ideology, 1269–1272, Nov 1973
Tomlinson KE: see Hankoff LD, jt au
Torrey EF: Book Review of J Cawte: Cruel, Poor and Brutal Nations, 1051–1052, Sept 1973
Torrey EF, Taylor RL: Cheap labor from poor nations, 428–433, April 1973
Tragellis GS: see Bendt RH, jt au
Travis JC: *Journal*'s culpa? (Ltr to Ed), 328, Mar 1973
Travis TA, Kondo CY, Knott JR: Interaction of hypnotic suggestion and alpha enhancement, 1389–1391, Dec 1973
Treffert DA: "Dying with their rights on" (Ltr to Ed), 1041, Sept 1973
Tucker GJ: see Reilly FE, jt au
Tucker GJ, Harrow M, Quinlan D: Depersonalization, dysphoria, and thought disturbance, 702–706, June 1973
Tucker GJ, Maxmen JS: The practice of hospital psychiatry: a formulation, 887–891, Aug 1973

Ullman M: Book Review of B Landis, ES Tauber (eds): In the Name of Life: Essays in Honor of Erich Fromm, 827, July 1973
Ullrich JR: Side effects of methylphenidate (Ltr to Ed), 941, Aug 1973
Urcuyo L: see Marcos LR, jt au
U'Ren RC, Conrad FE, Patterson PH: A year's experience in student mental health at West Point, 643–647, June 1973

Vaillant GE: Book Review of L Brill: The De-Addiction Process: Studies in the De-Addiction of Confirmed Heroin Addicts, 1405, Dec 1973
Valente M: Book Review of LB Holmes, HW Moser, S Halldórsson, C Mack, SS Pant, B Matzilevich: Mental Retardation: An Atlas of Diseases with Associated Physical Abnormalities, 1166, Oct 1973
Valles JV: see Ananth JV, jt au
Van Lawick-Goodall J: The behavior of chimpanzees in their natural habitat, 1–12, Jan 1973
Van Praag HM, Dols LCW: Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, 801–804, July 1973
Varela AM: Internship for psychiatrists (Ltr to Ed), 1295–1296, Nov 1973
Vaughan WT Jr, Newman DE, Levy A, Marty S: The private practice of community psychiatry, 24–27, Jan 1973
Vidaver RM, Carson JE: A new framework for baccalaureate careers in the human services, 474–478, April 1973
Villeneuve C: see Sigal JJ, jt au
Vogel DB: see Hampton PT, jt au
Von Brauchitsch H: reply to G Mellsop, S Whittingham, Antinuclear factor: age and sex (Ltr to Ed), 609, May 1973
Von Loetzen IS: see Peele R, jt au
Von Mering O: Book Review of I Galdston (ed): The Interface between Psychiatry and Anthropology, 117–118, Jan 1973
Voth HM: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 225, Feb 1973

Wakefield H: see Werkman SL, jt au
Waldron J: Teaching communication skills in medical school, 579–581, May 1973
Walker WR, Parsons LB, Skelton WD: Brief hospitalization on a crisis service: a study of patient and treatment variables, 896–900, Aug 1973
Wang RP: Adolf Meyer and psychobiology (Ltr to Ed), 824, July 1973
Ward MP: see Fabian JJ, jt au
Warheit GJ: see Schwab JJ, jt au
Watts A: see Gordon RE, jt au
Waziri R: Symptomatology of depressive illness in Afghanistan, 213–217, Feb 1973
Weaver SC, Tennant FS Jr: Effectiveness of drug education programs for secondary school students, 812–814, July 1973
Wehlage DF: Drug dosage in ECT (Ltr to Ed), 1293, Nov 1973
Weingarten R: Early childhood illness and choosing the medical profession (Ltr to Ed), 1295, Nov 1973
Weingartner H: see Henry GM, jt au
Weinstein AS, DiPasquale D, Winsor F: Relationships between length of stay in and out of the New York State mental hospitals, 904–909, Aug 1973
Weiss BL, McPartland RJ, Kupfer DJ: Once more: the inaccuracy of non-EEG estimations of sleep, 1282–1285, Nov 1973
Weissman M, Fox K, Klerman GL: Hostility and depression associated with suicide attempts, 450–455, April 1973
Wender PH: Book Review of C Anderson: Society Pays: The High Costs of Minimal Brain Damage in America, 726–727, June 1973
Weppner RS: see Stephens RC, jt au
Werkman SL: Book Review of R Kastenbaum, R Aisenberg: The Psychology of Death, 500, April 1973
Werkman SL, Landau S, Wakefield H: Medical students view clinical psychiatry, 562–565, May 1973
Werman DS: True and false experts: a second look, 1351–1354, Dec 1973
Werner A: The responsibilities of psychiatry to medicine: a debate (Ltr to Ed), 224, Feb 1973
Wertz WJ: see Hamid TA, jt au
West LJ: The future of psychiatric education, 521–528, May 1973
Westman JC: Book Review of RL Noland (ed): Counseling Parents of the Emotionally Disturbed Child, 833, July 1973
Westman JS: Book Review of M Rutter (ed): Infantile Autism: Concepts, Characteristics and Treatment, 502, April 1973
Whitelaw JP: see Ananth JV, jt au
Whitman RM: see Winget CN, jt au
Whittingham S: see Mellsop G, jt au
Wilbur CB: discussion of MT Notman, CC Nadelson, Medicine: a career conflict for women, 1126–1127, Oct 1973
Wilkerson R: see Bernard V, jt au
Will OA Jr: see Schimel JL, jt au
Williams WS: Report of the Speaker-Elect (Off Acts), 1191–1192, Oct 1973
Wilson IC: see Fann WE, jt au
Wineburg EN, Straker N: An episode of acute, self-limiting depersonalization following a first session of hypnosis, 98–100, Jan 1973
Wineburg EN, Straker N: reply to E Klemperer, The safety of hypnoses (Ltr to Ed), 1045, Sept 1973
Winget CN, Whitman RM: Coping with problems: attitudes toward children who set fires, 442–445, April 1973
Winn JA: Treatment for tardive dyskinesia (Ltr to Ed), 496, April 1973
Winokur G: Depression in the menopause, 92–93, Jan 1973
Winsberg BG: reply to JR Ullrich, Side effects of methylphenidate (Ltr to Ed), 941–942, Aug 1973
Winsberg BG: see Brown D, jt au
Winsor F: see Weinstein AS, jt au
Winston F: Oral contraceptives, pyridoxine, and depression, 1217–1221, Nov 1973

Wintrob RM: see Becker RE, jt au
Wold P: Family structure in three cases of anorexia nervosa: the role of the father, 1394–1397, Dec 1973
Wolford JA: The Council on Internal Organization (Off Acts), 518–520, April 1973
Wolpe J, Brady JP, Serber M, Agras WS, Liberman RP: The current status of systematic desensitization, 961–965, Sept 1973
Work HH: Book Review of S Chess, A Thomas (eds): Annual Progress in Child Psychiatry and Child Development: 1972, 728, June 1973
Work HH: Book Review of PH Wender: The Hyperactive Child: A Handbook for Parents, 1405, Dec 1973
Workneh F: see Miller MH, jt au
Wortis J: reply to RH Ingwell, Testing for mental retardation: comments on standard deviations (Ltr to Ed), 496, April 1973
Wyatt RJ, Saavedra JM, Axelrod J: A dimethyltryptamine-forming enzyme in human blood, 754–760, July 1973
Wyatt RJ, Saavedra JM, Belmaker R, Cohen S, Pollin W: The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, 1359–1361, Dec 1973
Yager J: Intellectual impairment in uremic patients (Ltr to Ed), 1159–1160, Oct 1973
Yamamoto J: see Chameides WA, jt au
Yaryura-Tobías JA: Behavioral-gluco-dysrythmic triad (Ltr to Ed), 825, July 1973
Young LD, Suomi SS, Harlow HF, McKinney WT Jr: Early stress and later response to separation in rhesus monkeys, 400–405, April 1973
Yusin AS: Confusion about schizophrenia (Ltr to Ed), 1400, Dec 1973

Zalcman S, Liskow B, Cadoret R, Goodwin D: Marijuana and amphetamine: the question of interaction, 707–708, June 1973
Zeller WW: Book Review of IS Cooper: The Victim Is Always the Same, 1299–1300, Nov 1973
Zeller WM: Book Review of DB Schuster, JJ Sandt, OF Thaler: Clinical Supervision of the Psychiatric Resident, 829, July 1973
Zusman J, Shaffer S: Emergency psychiatric hospitalization via court order: a critique, 1323–1326, Dec 1973

Subject Index

ABORTION

Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
Motivational factors in abortion patients, FJ Kane Jr, PA Lachenbruch, MA Lipton, D Baram, 290–293, Mar 1973
Therapeutic abortion and a prior psychiatric history, JA Ewing, BA Rouse, 37–40, Jan 1973

ACUPUNCTURE

Acupunctural analgesia: its explanation by conditioning theory, autogenic training, and hypnosis, WS Kroger, 855–860, Aug 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973

ADMINISTRATIVE PSYCHIATRY

The attitudes of patients and aides toward the role of the psychiatric aide, L Handler, G Perlman, 322–325, Mar 1973
Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
The clinical case conference reconsidered, JR McNamara, 1153–1154, Oct 1973
Dumping of patients: funding and statistics a problem (Ltr to Ed), HM Kase, 111, Jan 1973
How success nearly wrecked a residency experience, FM Kline, 1038–1040, Sept 1973
Participatory management in psychiatry, DE Raskin, 219–221, Feb 1973

ADOLESCENCE

The behavior of chimpanzees in their natural habitat, J Van Lawick-Goodall, 1–12, Jan 1973
The concept of child advocacy, JF McDermott Jr, WM Bolman, AM Arensdorf, RA Markoff, 1203–1206, Nov 1973
Effectiveness of drug education programs for secondary school students, SC Weaver, FS Tennant Jr, 812–814, July 1973
The effects of social prejudice on hospitalized adolescents, PG Rossman, D Miller, 1029–1031, Sept 1973
A hospital riot: its determinants and implications for treatment, RC Marohn, D Dalle-Molle, D Offer, E Ostrov, 631–636, June 1973
Hyperkinetic children and the Staccato syndrome (Ltr to Ed), L Tec, 330, Mar 1973
Indian education: a human systems analysis, CA Hammerschlag, CP Alderfer, D Berg, 1098–1102, Oct 1973
The mystical experience as a suicide preventive, PC Horton, 294–296, Mar 1973
Sexual freedom in adolescents: a reaction formation? (Ltr to Ed), WV Hempel, 722, June 1973
Teenage helper: a role in community mental health, GA Rogeness, RA Bednar, 933–936, Aug 1973
The therapeutic utilization of the juvenile court, Y Nir, R Cutler, 1112–1117, Oct 1973

AFFECTIVE DISORDER

Antagonistic effects of physostigmine and methylphenidate in man, DS Janowsky, MK El-Yousef, JM Davis, HJ Sekerke, 1370–1376, Dec 1973
Antinuclear factor: age and sex (Ltr to Ed), G Mellsop, S Whittingham, and reply of H von Brauchitsch, 609, May 1973
Cerebrospinal fluid amine metabolites in affective illness: the probenecid technique, FK Goodwin, RM Post, DL Dunner, EK Gordon, 73–79, Jan 1973
Depersonalization, dysphoria, and thought disturbance, GJ Tucker, M Harrow, D Quinlan, 702–706, June 1973
Depression in the menopause, G Winokur, 92–93, Jan 1973
Drug treatment of depressed patients referred for hospitalization, J Kotin, RM Post, FK Goodwin, 1139–1141, Oct 1973
Early stress and later response to separation in rhesus monkeys, LD Young, SS Suomi, HF Harlow, WT McKinney Jr, 400–405, April 1973
Growth hormone and prolactin in unipolar and bipolar depressed patients: responses to hypoglycemia and L-dopa, EJ Sachar, AG Frantz, N Altman, J Sassin, 1362–1367, Dec 1973
Historical background in children with affective disorders, DH McKnew Jr, L Cytryn, 1278–1280, Nov 1973
Hopelessness, depression, and attempted suicide, K Minkoff, E Bergman, AT Beck, R Beck, 455–459, April 1973
Hostility and depression associated with suicide attempts, M Weissman, K Fox, GL Klerman, 450–455, April 1973
Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973
Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
L-dopa, dopamine, and hypomania, DL Murphy, FK Goodwin, HKH Brodie, WE Bunney Jr, 79–82, Jan 1973
Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973
Manic-depressive illness: linkage with the Xg blood group, RR Fieve, J Mendlewicz, JL Fleiss, 1355–1359, Dec 1973
Mental health of political candidates: notes on Abraham Lincoln (Ltr to Ed), RW Hudgens, 110, Jan 1973
Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, JJ Schildkraut, 695–699, June 1973
Oral contraceptives, pyridoxine, and depression, F Winston, 1217–1221, Nov 1973
Plasma binding of imipramine and clinical outcome, AH Glassman, MJ Hurwic, JM Perel, 1367–1369, Dec 1973
Psychomotor activity and cerebrospinal fluid amine metabolites in affective illness, RM Post, J Kotin, FK Goodwin, EK Gordon, 67–72, Jan 1973
Relationship between the effectiveness of lithium therapy and family history, J Mendlewicz, RR Fieve, F Stallone, 1011–1013, Sept 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973
Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, LR Loeb, S Peal, FF Loeb Jr, B Templeton, 160–164, Feb 1973
Sensitivity reaction to imipramine (Ltr to Ed), WS Ryback, PA Jorgensen, SE Jorgensen, 940, Aug 1973
Single versus divided daily dose of trimipramine in the treatment of depressive illness, MZ Hussain, AZ Chaudhry, 1142–1144, Oct 1973
Symptomatology of depressive illness in Afghanistan, R Waziri, 213–217, Feb 1973
The treatment of depression with a single daily dose of imipramine pamoate, J Mendels, J DiGiacomo, 1022–1024, Sept 1973
The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness, F Stallone, E Shelley, J Mendlewicz, RR Fieve, 1006–1010, Sept 1973

AGGRESSION AND VIOLENCE

Aggression and social synergy (Editorial), CD Aring, 297–298, Mar 1973
The behavior of chimpanzees in their natural habitat, J Van Lawick-Goodall, 1–12, Jan 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RM Whitman, 442–445, April 1973
Countertransference reactions to violent patients, JR Lion, SA Pasternak, 207–210, Feb 1973
Epidemiological studies of women prisoners, I: medical and psychiatric variables related to violent behavior, CE Climent, A Rollins, FR Ervin, R Plutchik, 985–990, Sept 1973
A hospital riot: its determinants and implications for treatment, RC Marohn, D Dalle-Molle, E Offer, E Ostrov, 631–636, June 1973
Is psychiatry as establishment an effective force? MH Miller, J Auerbach, 761–764, July 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
Position statement on homicide prevention (Off Acts), 391, Mar 1973
A proposed "dangerous sex offender" law, NT Sidley, FJ Stolarz, 765–768, July 1973
Resentment and suspicion among American men, MD Blumenthal, 876–880, Aug 1973

AGRANULOCYTOSIS

Usual and unusual agranulocytosis during neuroleptic therapy, JV Ananth, JV Valles, JP Whitelaw, 100–102, Jan 1973

ALCOHOL THERAPY

Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, C-p Chien, BA Stotsky, JO Cole, 543–548, May 1973

ALCOHOLISM

Alcoholics' patterns of controlled drinking, E Gottheil, AI Alterman, TE Skoloda, BF Murphy, 418–422, April 1973
Alcohol-induced sexual impotence, F Lemere, JW Smith, 212–213, Feb 1973
Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973
Chlorpromazine contraindicated in delirium tremens (Ltrs to Ed), R Kalda and GA Rogers, and reply of JL Chapel, 1042–1043, Sept 1973
A comprehensive alcoholism program in the Army, BG Fiman, DR Conner, AC Segal, 532–535, May 1973
Contradictions in the alcoholism criteria (Ltr to Ed), EF Kal, and reply of FA Seixas, 606, May 1973
Dreams as a prognostic factor in alcoholism, SY Choi, 699–702, June 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Evidence for polygenetic inheritance in the hyperactive child syndrome, JR Morrison, MA Stewart, 791–792, July 1973
Factors in the description and grouping of alcoholics, RC Evenson, H Altman, IW Sletten, RR Knowles, and discussion by EM Caffey Jr, 49–54, Jan 1973
Indian peyotists and alcohol (Ltr to Ed), C Roy, 329–330, Mar 1973
Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1381–1382, Dec 1973
Use of alcohol by addict and nonaddict populations, BS Brown, NJ Kozel, MB Meyers, RL DuPont, 599–601, May 1973

ALPHA-METHYL-PARATYROSINE

Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

The American Board of Psychiatry and Neurology (Off Acts), 122–124, Jan 1973
The American Board of Psychiatry and Neurology (Off Acts), 839–840, July 1973
1973 Annual Report of the American Board of Psychiatry and Neurology, Inc (Off Acts), 1193–1194, Oct 1973
The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), JC Beck, M Braun, NQ Brill, JS Eaton Jr, KE Godfrey, KH Gruberg, JA Kindwall, B Kuhner, B Liptzin, RT London, JL Mathis, AE Penetrante, AT Sorvino, HM Voth, and A Werner, and reply of GL Engel, 223–227, Feb 1973

AMERICAN JOURNAL OF PSYCHIATRY

Fewer special sections in the offing (Editorial), FJ Braceland, 1020–1021, Sept 1973
Journal's culpa? (Ltr to Ed), JC Travis, and reply of Z Giora, 328, Mar 1973
Kudos (Editorial), FJ Braceland, 473, April 1973
More changes for the *Journal* (Editorial), FJ Braceland, 205–206, Feb 1973
The need for feedback to authors (Ltr to Ed), G Gardos, and Editor's note by FJ Braceland, 824–825, July 1973
A year of change—a card of thanks (Editorial), FJ Braceland, 89–91, Jan 1973

AMERICAN PSYCHIATRIC ASSOCIATION

The Assembly of District Branches (Off Acts), 520, April 1973
Assessing self-assessment (Ltrs to Ed), M Malcolm and HL Newbold, and reply of HT Carmichael, 1161–1162, Oct 1973
Committee on Certification in Administrative Psychiatry (Off Acts), 952, Aug 1973
The Council on Emerging Issues (Off Acts), ET Auer, 514–515, April 1973
The Council on Internal Organization (Off Acts), JA Wolford, 518–520, April 1973
The Council on International Affairs (Off Acts), HP Rome, 516, April 1973
The Council on Medical Education and Career Development (Off Acts), AJ Silverman, 507–509, April 1973
The Council on Mental Health Services (Off Acts), EO Harper, 510–511, April 1973
The Council on National Affairs (Off Acts), LC Kolb, 513–514, April 1973
The Council on Professions and Associations (Off Acts), RS Garber, 516–518, April 1973
The Council on Research and Development (Off Acts), RR Monroe, 512–513, April 1973
"Diagnosing" political candidates (Ltr to Ed), VM Cox Jr, 109–110, Jan 1973
Foreign medical graduates: a symposium, MH Miller, F Workneh, EB Brody, DJ Lewis, T-y Lin, and discussion by L Ganser, B Holland, J Smith e Incas, W Shervington, JS Steinberg, CH Fellner, 435–441, April 1973
Highlights of the 126th annual meeting (Off Acts), RW Gibson, 837–839, July 1973
If they were here now (Editorial), JM Myers, 910–911, Aug 1973
Is psychiatry as establishment an effective force? MH Miller, J Auerbach, 761–764, July 1973

Joint statement on antisubstitution laws and regulations (Off Acts), 741, June 1973
More changes for the *Journal* (Editorial), FJ Braceland, 205–206, Feb 1973
The need for feedback to authors (Ltr to Ed), G Gardos, and Editor's note by FJ Braceland, 824–825, July 1973
1973 annual meeting preliminary program (Off Acts), 341–380, Mar 1973
Peer review: prospects and problems, DG Langsley, 301–304, Mar 1973
Perry Clement Talkington, M.D., one hundred and first President, 1972–1973, HW Brosin, 750–753, July 1973
Position statement on aging (Off Acts), 950–951, Aug 1973
Position statement on college mental health (Off Acts), 740, June 1973
Position statement on community mental health centers (Off Acts), 239–240, Feb 1973
Position statement on the confidentiality of medical research records (Off Acts), 739, June 1973
Position statement on homicide prevention (Off Acts), 391, Mar 1973
Position statement on involuntary hospitalization of the mentally ill (revised) (Off Acts), 392, Mar 1973
Position statement on peer review in psychiatry (Off Acts), 381–385, Mar 1973
Position statement on psychiatrists' relationships with nonmedical mental health professionals (Off Acts), 386–390, Mar 1973
The Presidential Address: a time for action, PC Talkington, 745–747, July 1973
The Principles of Medical Ethics with annotations especially applicable to psychiatry (Off Acts), 1057–1064, Sept 1973
Proposed amendments to the Constitution and By-Laws (Off Acts), 1195–1196, Oct 1973
Report of the Medical Director (Off Acts), WE Barton, 1187–1188, Oct 1973
Report of the Secretary: summary of meetings of Board of Trustees and Executive Committee, May 1972–May 1973 (Off Acts), RW Gibson, 1177–1183, Oct 1973
Report of the Speaker (Off Acts), JC Johnson Jr, 1189–1190, Oct 1973
Report of the Speaker-Elect (Off Acts), WS Williams, 1191–1192, Oct 1973
Report of the Treasurer (Off Acts), HH Donahue, 1184–1186, Oct 1973
Response to the Presidential Address, AM Freedman, 748–749, July 1973
The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), JC Beck, M Braun, NQ Brill, JS Eaton Jr, KE Godfrey, KH Gruberg, JA Kindwall, B Kuhner, B Liptzin, RT London, JL Mathis, AE Penetrante, AR Sorvino, HM Voth, and A Werner, and reply of GL Engel, 223–227, Feb 1973
The role of psychiatry in war and poverty (Ltr to Ed), V Bernard, J Bullette, R Gorney, L Grinspoon, J Handler, J Marmor, R Menninger, P Ottenberg, K Smith, R Wilkerson, 109, Jan 1973
Statements about Viet Nam: APA's role (Ltrs to Ed), H Corral and WC Johnson, 721–722, June 1973
Suicide and the psychiatrist (Ltr to Ed), M Ross, 937, Aug 1973
Summary report of the special policy meeting of the Board of Trustees, Atlanta, Ga, February 1–3, 1973 (Off Acts), 732–738, June 1973
A symposium: should homosexuality be in the APA nomenclature? RJ Stoller, J Marmor, I Bieber, R Gold, CW Socarides, R Green, RL Spitzer, 1207–1216, Nov 1973
Viet Nam: the Board of Trustees steps out of bounds (Ltr to Ed), EJ Gunderson, 610, May 1973

AMITRIPTYLINE

Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, JJ Schildkraut, 695–699, June 1973

AMNESIA

Amnesia and competency to stand trial, D Koson, A Robey, and discussion by LC Maguigad, 588–592, May 1973

AMPHETAMINES

Amphetamine psychosis: a "model" schizophrenia mediated by catecholamines, SH Snyder, 61–67, Jan 1973
Biochemical aspects of sensitivity reactions (Ltr to Ed), MP Chinoy, 1402, Dec 1973
Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Evolving behavior in the clinical and experimental amphetamine (model) psychosis, EH Ellinwood Jr, A Sudilovsky, LM Nelson, 1088–1093, Oct 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Marijuana and amphetamine: the question of interaction, S Zalcman, B Liskow, R Cadoret, D Goodwin, 707–708, June 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973

ANIMAL STUDIES

The behavior of chimpanzees in their natural habitat, J Van Lawick-Goodall, 1–12, Jan 1973
Early stress and later response to separation in rhesus monkeys, LD Young, SS Suomi, HF Harlow, WT McKinney Jr, 400–405, April 1973
Evolving behavior in the clinical and experimental amphetamine (model) psychosis, EH Ellinwood Jr, A Sudilovsy, LM Nelson, 1088–1093, Oct 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973

ANOREXIA NERVOSA

Family structure in three cases of anorexia nervosa: the role of the father, P Wold, 1394–1397, Dec 1973

ATTITUDE SURVEYS

The attitudes of patients and aides toward the role of the psychiatric aide, L Handler, G Perlman, 322–325, Mar 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RM Whitman, 442–445, April 1973
Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
Opinions about mental illness and political ideology, A Tolor, 1269–1272, Nov 1973
Popular attitudes and beliefs about tranquilizers, DI Manheimer, ST Davidson, MB Balter, GD Mellinger, IH Cisin, HJ Parry, 1246–1253, Nov 1973
Psychiatric residents: a survey of training needs, satisfactions, and social attitudes, FE Fried, EG Doherty, L Coyne, 1342–1345, Dec 1973
Resentment and suspicion among American men, MD Blumenthal, 876–880, Aug 1973
A survey of attitudes of chairmen of departments of psychiatry toward community mental health, AF Panzetta, RB Sloane, H Aronson, 175–178, Feb 1973
A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients, SH Kardener, M Fuller, IN Mensh, 1077–1081, Oct 1973

AUTOMATED HEALTH TESTING

Psychiatric screening with automated multiphasic health testing in the VA admission procedure, RE Gordon, L Bielen, A Watts, 46–48, Jan 1973

BEHAVIORAL PSYCHIATRY

Acupunctural analgesia: its explanation by conditioning theory, autogenic training, and hypnosis, WS Kroger, 855–860, Aug 1973
Clinical and theoretical consequences of the misuse of basic behavior therapy concepts, DL Braff, 818–819, July 1973
The current status of systematic desensitization, J Wolpe, JP Brady, M Serber, WS Agras, RP Liberman, 961–965, Sept 1973
The eclectic approach to the treatment of phobias, KR MacKenzie, and discussion by EM Caffey Jr, 1103–1106, Oct 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973
Video feedback in treating hyperkinetic children: a preliminary report, S Furman, A Feighner, 792–796, July 1973

BIOCHEMICAL PSYCHIATRY

Adolf Meyer and psychobiology (Ltr to Ed), RP Wang, 824, July 1973
Amphetamine psychosis: a "model" schizophrenia mediated by catecholamines, SH Snyder, 61–67, Jan 1973
Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973
Antagonistic effects of physostigmine and methylphenidate in man, DS Janowsky, MK El-Yousef, JM Davis, HJ Sekerke, 1370–1376, Dec 1973
Biochemical aspects of sensitivity reactions (Ltr to Ed), MP Chinoy, 1402, Dec 1973
Biological psychiatry (Editorial), JM Davis, 87–88, Jan 1973
Cerebrospinal fluid amine metabolites in affective illness: the probenecid technique, FK Goodwin, RM Post, DL Dunner, EK Gordon, 73–79, Jan 1973
The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
A dimethyltryptamine-forming enzyme in human blood, RJ Wyatt, JM Saavedra, J Axelrod, 754–760, July 1973
The dream-protein hypothesis, EL Rossi, 1094–1097, Oct 1973
Evolving behavior in the clinical and experimental amphetamine (model) psychosis, EH Ellinwood Jr, A Sudilovsky, LM Nelson, 1088–1093, Oct 1973
Growth hormone and prolactin in unipolar and bipolar depressed patients: responses to hypoglycemia and L-dopa, EJ Sachar, AG Frantz, N Altman, J Sassin, 1362–1367, Dec 1973
Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973
Imipramine withdrawal: an akathisia-like syndrome, GL Sathananthan, S Gershon, 1286–1287, Nov 1973
Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
L-dopa, dopamine, and hypomania, DL Murphy, FK Goodwin, HKH Brodie, WE Bunney Jr, 79–82, Jan 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973
Manic-depressive illness: linkage with the Xg blood group, RR Fieve, J Mendlewicz, JL Fleiss, 1355–1359, Dec 1973
Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, JJ Schildkraut, 695–699, June 1973
Oral contraceptives, pyridoxine, and depression, F Winston, 1217–1221, Nov 1973
The pharmacology of tardive dyskinesias, HL Klawans Jr, 82–86, Jan 1973
Plasma binding of imipramine and clinical outcome, AH Glassman, MJ Hurwic, JM Perel, 1367–1369, Dec 1973
Psychomotor activity and cerebrospinal fluid amine metabolites in affective illness, RM Post, J Kotin, FK Goodwin, EK Gordon, 67–72, Jan 1973
Relationship between the effectiveness of lithium therapy and family history, J Mendlewicz, RR Fieve, F Stallone, 1011–1013, Sept 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
Urinary cyclic AMP in periodic catatonia, TL Perry, S Hemmings, GI Drummond, S Hansen, LR Gjessing, 927–929, Aug 1973

BIOFEEDBACK

Interaction of hypnotic suggestion and alpha enhancement, TA Travis, CY Kondo, JR Knott, 1389–1391, Dec 1973

BIRTH CONTROL

Motivational factors in abortion patients, FJ Kane Jr, PA Lachenbruch, MA Lipton, D Baram, 290–293, Mar 1973
Oral contraceptives, pyridoxine, and depression, F Winston, 1217–1221, Nov 1973
The psychiatrist and family planning (Editorial), EB Brody, 1273–1274, Nov 1973

BOOK REVIEWS

Agras WS (ed): Behavior Modification: Principles and Clinical Applications, 1408, Dec 1973
Alcohol and Health. Report from the Secretary of Health, Education, and Welfare, 1165–1166, Oct 1973
Altman RA, Byerly CM (eds): The Public Challenge and the Campus Response, 114, Jan 1973
Alvarez A: The Savage God: A Study of Suicide, 1405–1406, Dec 1973
Anderson C: Society Pays: The High Costs of Minimal Brain Damage in America, 726–727, June 1973
Arieti S: The Will To Be Human, 501, April 1973

Baldwin JA: The Mental Hospital in the Psychiatric Service: A Case-Register Study, 501–502, April 1973
Balint M, Ornstein PH, Balint E: Focal Psychotherapy: An Example of Applied Psychoanalysis, 828–829, July 1973
Bannister R (reviser): Brain's Clinical Neurology, 4th ed, 1409, Dec 1973
Berkey BR: Halfway Through the Tunnel, 1406, Dec 1973
Bleuler M: Die schizophrenen Geistesstörungen, 332, Mar 1973
Borger R, Cioffi F (eds): Explanation in the Behavioural Sciences, 114–115, Jan 1973
Bridge CJ: Alcoholism and Driving, 1409, Dec 1973
Brill L: The De-Addiction Process: Studies in the De-Addiction of Confirmed Heroin Addicts, 1405, Dec 1973
British Medical Association Journal Department: The Mental Health Service after Unification: Mental Health in a Unified National Health Service—Report of the Tripartite Committee, 333, Mar 1973
Brown CC, Savage C (eds): The Drug Abuse Controversy, 1301, Nov 1973
Brown FC: Hallucinogenic Drugs, 1304, Nov 1973
Brožek J, Slobin DI (eds): Psychology in the USSR: An Historical Perspective, 832–833, July 1973
Bry A: Inside Psychotherapy, 117, Jan 1973
Bursten B: The Manipulator: A Psychoanalytic View, 1302, Nov 1973

Cahn S: The Treatment of Alcoholics: An Evaluative Study, 1052, Sept 1973
Carasov V: Two Gentlemen To See You, Sir: The Autobiography of a Villain, 232–233, Feb 1973
Carek DJ: Principles of Child Psychotherapy, 232, Feb 1973
Cawte J: Cruel, Poor and Brutal Nations, 1051–1052, Sept 1973
Chein I: The Science of Behavior and the Image of Man, 832, July 1973
Chess S, Thomas A (eds): Annual Progress in Child Psychiatry and Child Development: 1971, 336–337, Mar 1973
Chess S, Thomas A (eds): Annual Progress in Child Psychiatry and Child Development: 1972, 728, June 1973
Claridge G, Canter S, Hume WI: Personality Differences and Biological Variations: A Study of Twins, 1299, Nov 1973
Cole JP: The Problematic Self in Kierkegaard and Freud, 1049–1050, Sept 1973
Cooper IS: The Victim Is Always the Same, 1299–1300, Nov 1973
Cooper JE, Kendell RE, Gurland BJ, Sharpe L, Copeland JRM, Simon R: Psychiatric Diagnosis in New York and London: A Comparative Study of Mental Hospital Admissions, 613, May 1973

De Ajuriaguerra J: Manuel de Psychiatrie de l'Enfant, 1300, Nov 1973
De Beauvoir S: The Coming of Age, 331–332, Mar 1973
De la Cruz FF, LaVeck GD (eds): Human Sexuality and the Mentally Retarded, 1171, Oct 1973
Dewald PA: The Psychoanalytic Process: A Case Illustration, 231–232, Feb 1973
DeYoung CD, Tower M: The Nurse's Role in Community Mental Health Centers, 1053, Sept 1973
Di Loreto AO: Comparative Psychotherapy: An Experimental Analysis, 229, Feb 1973
Dobzhansky T: Genetic Diversity and Human Equality, 1169–1170, Oct 1973
Drug Use in America: Problems in Perspective. Second Report of the National Commission on Marihuana and Drug Abuse, 1164–1165, Oct 1973

Efron DH (ed): Psychotomimetic Drugs, 945–946, Aug 1973
Ehrhardt HE: 130 Jahre: Deutsche Geselschaft für Psychiatrie und Nervenheilkunde, 945, Aug 1973
Eissler KR: Talent and Genius: The Fictitious Case of Tausk Contra Freud, 1302–1303, Nov 1973
Eleftheriou BE, Scott JP (eds): The Physiology of Aggression and Defeat, 335–336, Mar 1973
Ennis B: Prisoners of Psychiatry: Mental Patients, Psychiatrists and the Law, 725–726, June 1973
Evans WD, Kline NS (compilers and eds): Psychotropic Drugs in the Year 2000: Use by Normal Humans, 617, May 1973

Ferber A, Mendelsohn M, Napier A: The Book of Family Therapy, 830–831, July 1973
Fine BD, Joseph ED, Waldhorn HF (eds): Recollection and Reconstruction; Reconstruction in Psychoanalysis, 117, Jan 1973
Fliess R: Symbol, Dream, and Psychosis, 1169, Oct 1973
Freedman AM, Kaplan HI, Sadock BJ: Modern Synopsis of *Comprehensive Textbook of Psychiatry*, 613–614, May 1973
Freidson E: Profession of Medicine: A Study of the Sociology of Applied Knowledge, 498–499, April 1973
Frosch J, Ross N (eds): The Annual Survey of Psychoanalysis, vol 10: A Comprehensive Survey of Current Psychoanalytic Theory and Practice, 116–117, Jan 1973

Galdston I (ed): The Interface between Psychiatry and Anthropology, 117–118, Jan 1973
Garber B: Follow-up Study of Hospitalized Adolescents, 829–830, July 1973
Glasscote RM, Fishman ME, Sonis M: Children and Mental Health Centers: Programs, Problems, Prospects, 827–828, July 1973

Hale NG Jr: Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876–1917, 500–501, April 1973
Haley J: Uncommon Therapy, 1303, Nov 1973
Harris TA: I'm OK—You're OK: A Practical Guide to Transactional Analysis, 1173–1174, Oct 1973
Harrison SI, McDermott JD (eds): Childhood Psychopathology, 612–613, May 1973
Hendin D: Death as a Fact of Life, 831–832, July 1973
Holmes DJ: Psychotherapy: Experience, Behavior, Mentation, Communication, Culture, Sexuality, and Clinical Practice, 944, Aug 1973
Holmes LB, Moser HW, Halldórsson S, Mack C, Pant SS, Matzilevich B: Mental Retardation: An Atlas of Diseases with Associated Physical Abnormalities, 1166, Oct 1973
Howells JG: Theory and Practice of Family Psychiatry, 614–615, May 1973
Howells JG (ed): Modern Perspectives in World Psychiatry, 229–230, Feb 1973

Israel Y, Mardones J (eds): Biological Basis of Alcoholism, 1049, Sept 1973

Jacobson E: Depression: Comparative Studies of Normal, Neurotic, and Psychiatric Conditions, 498, April 1973

Kahan VL: Mental Illness in Childhood: A Study of Residential Treatment, 235, Feb 1973
Kaplan AR (ed): Genetic Factors in "Schizophrenia," 113–114, Jan 1973
Kaplan BH (ed), with Leighton AH, Murphy JM, Freydberg N: Psychiatric Disorder and the Urban Environment, 233–234, Feb 1973
Kaplan HI, Sadock BJ (eds): Comprehensive Group Psychotherapy, 1404, Dec 1973
Kastenbaum R, Aisenberg R: The Psychology of Death, 500, April 1973
Katz E (ed): Mental Health Services for the Mentally Retarded, 833, July 1973
Katz J, with Capron AM, Glass ES: Experimentation with Human Beings: The Authority of the Investigator, Subject, Professions, and State in the Human Experimentation Process, 228–229, Feb 1973
Kelman H: Helping People: Karen Horney's Psychoanalytic Approach, 112–113, Jan 1973
Kestemberg E, Kestemberg J, Decobert S: La faim et le corps: Une étude psychanalytique de l'anorexie mentale, 1052, Sept 1973
Kline P: Fact and Fantasy in Freudian Theory, 1172, Oct 1973
Kohut H: The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders, 1171–1172, Oct 1973
Kolb LC: Modern Clinical Psychiatry, 8th ed, 943–944, Aug 1973
Kolb LC, Bernard VW, Dohrenwend BP (eds): Urban Challenges to Psychiatry, 725, June 1973
Kooi KA: Fundamentals of Electroencephalography, 1050–1051, Sept 1973
Kraepelin E (tr by RM Barclay): Dementia Praecox and Paraphrenia (facsimile edition), 1167–1168. Oct 1973
Kuiper PC: The Neuroses: A Psychoanalytic Survey, 727–728, June 1973
Kutscher AH, Kutscher LG (eds): Religion and Bereavement: Counsel for the Physician, Advice for the Bereaved, Thoughts for the Clergyman, 502–503, April 1973

Landis B, Tauber ES (eds): In the Name of Life: Essays in Honor of Erich Fromm, 827, July 1973
Langer WC: The Mind of Adolf Hitler: The Secret Wartime Report, 499, April 1973
Lebra WP (ed): Transcultural Research in Mental Health, vol II of Mental Health Research in Asia and the Pacific, 1301–1302, Nov 1973
Leedy JJ (ed): Compensation in Psychiatric Disability and Rehabilitation, 727, June 1973
Lester D: Why People Kill Themselves: A Summary of Research Findings on Suicidal Behavior, 1048–1049, Sept 1973
Levine M: Psychiatry and Ethics, 1164, Oct 1973
Levinson H: Organizational Diagnosis, 1168–1169, Oct 1973
Lewis HB: Shame and Guilt in Neurosis, 615, May 1973
Liberman RP: A Guide to Behavioral Analysis and Therapy, 615–616, May 1973

Lieb J, Lipsitch II, Slaby AE: The Crisis Team: A Handbook for the Mental Health Professional, 944–945, Aug 1973
Lion JR: Evaluation and Management of the Violent Patient: Guidelines in the Hospital and Institution, 1166, Oct 1973

MacKenzie A: Apparitions and Ghosts: A Modern Study, 115–116, Jan 1973
Maher B (ed): Contemporary Abnormal Psychology: Selected Readings, 1406–1407, Dec 1973
Maletzky B, Blachly PH: The Use of Lithium in Psychiatry, 333–334, Mar 1973
Maslow AH: The Farther Reaches of Human Nature, 1303–1304, Nov 1973
Masserman JH (ed): Current Psychiatric Therapies, vol 11, 336, Mar 1973
Masserman JH (ed): Science and Psychoanalysis, vol XIX: Dream Dynamics, 616–617, May 1973
Masserman JH (ed): Science and Psychoanalysis, vol XX: The Dynamics of Power, 1408–1409, Dec 1973
Masterson JF: Treatment of the Borderline Adolescent: A Developmental Approach, 228, Feb 1973
Matarazzo JD, Bergin AE, Frank JD, Lang PJ, Marks IM, Strupp HH (eds): Psychotherapy: 1971, 1406, Dec 1973
Matthews WB, Miller H: Diseases of the Nervous System, 832, July 1973
Mayer MF (compiler and ed), Blum A: Healing Through Living: A Symposium on Residential Treatment, 832, July 1973
McClelland DC, Davis WN, Kalin R, Wanner E: The Drinking Man, 231, Feb 1973
McCully RS: Rorschach Theory and Symbolism: A Jungian Approach to Clinical Material, 1304–1305, Nov 1973
Meares A: A System of Medical Hypnosis, 1407, Dec 1973
Miller J-O: The Therapeutic Community with Chronic Mental Patients, 334, Mar 1973

Nahas GG: Marihuana–Deceptive Weed, 1407, Dec 1973
Neale RE: The Art of Dying, 1170, Oct 1973
Noland RL (ed): Counseling Parents of the Emotionally Disturbed Child, 833, July 1973

Orme JE, Spear FG: Psychology in Medicine, 614, May 1973
Ovesey L: Homosexuality and Pseudohomosexuality, 334–335, Mar 1973

Parens H, Saul LJ: Dependence in Man: A Psychoanalytic Study, 724, June 1973
Pavenstedt E, Bernard VW (eds): Crises of Family Disorganization: Programs to Soften Their Impact on Children, 230–231, Feb 1973
Pfeiffer E (ed): Sigmund Freud and Lou Andreas-Salomé: Letters, 724–725, June 1973

Rutter M (ed): Infantile Autism: Concepts, Characteristics and Treatment, 502, April 1973

Schuster DB, Sandt JJ, Thaler OF: Clinical Supervision of the Psychiatric Resident, 829, July 1973
Schutz WC: Here Comes Everybody: Bodymind and Encounter Culture, 1052–1053, Sept 1973
Shader RI (ed): Psychiatric Complications of Medical Drugs, 833, July 1973
Shamsie SJ (ed): Youth: Problems and Approaches, 831, July 1973
Sherman JA: On the Psychology of Women: A Survey of Empirical Studies, 1300–1301, Nov 1973
Shneidman ES (ed): Death and the College Student: A Collection of Brief Essays on Death and Suicide by Harvard Youth, 113, Jan 1973
Sifneos PE: Short-Term Psychotherapy and Emotional Crisis, 499–500, April 1973
Silverman HL (ed): Marital Therapy: Moral, Sociological and Psychological Factors, 616, May 1973
Singer J: Boundaries of the Soul, 830, July 1973
Skinner BF: Beyond Freedom and Dignity, 1047–1048, Sept 1973
Snyder SH (ed): Perspectives in Neuropharmacology: A Tribute to Julius Axelrod, 612, May 1973
Spiegel EA (ed): Progress in Neurology and Psychiatry: An Annual Review, vol XXVI, 233, Feb 1973
Steinberg DD, Jacobovits LA (eds): Semantics: An Interdisciplinary Reader in Philosophy, Linguistics and Psychology, 1166–1167, Oct 1973
Strahl MO, Lewis NDC (eds): Differential Diagnosis in Clinical Psychiatry: The Lectures of Paul H. Hoch, M.D., 1298, Nov 1973
Sullivan HS (ed by HS Perry, ML Gawel, M Gibbon): Clinical Studies in Psychiatry, 1047, Sept 1973

Tarshis MS: The LSD Controversy: An Overview, 1408, Dec 1973
Television and Growing Up: The Impact of Televised Violence. Report to the Surgeon General, 943, Aug 1973

Usdin G (ed): Perspectives on Violence, 234–235, Feb 1973

Viscott DS: The Making of a Psychiatrist, 332–333, Mar 1973

Weisman AD: On Dying and Denying: A Psychiatric Study of Terminality, 1298–1299, Nov 1973
Wender PH: The Hyperactive Child: A Handbook for Parents, 1405, Dec 1973
Whittington HG: Clinical Practice in Community Mental Health Centers, 1407–1408, Dec 1973
Whittington HG (ed): Development of an Urban Mental Health Center, 1173, Oct 1973
Williams CJ, Weinberg MS: Homosexuals and the Military, 1172–1173, Oct 1973
Wixen BN: Children of the Rich, 1051, Sept 1973
Wolberg LR, Schwartz EK (eds): Group Therapy: 1973—An Overview, 1170–1171, Oct 1973
Wortis J (ed): Mental Retardation, An Annual Review: III, 1305, Nov 1973

Zusman J, Davidson DL (eds): Organizing the Community to Prevent Suicide, 116, Jan 1973

BORDERLINE PATIENTS

Hospital treatment of borderline patients, G Adler, and discussion by OF Kernberg, 32–36, Jan 1973

CAFFEINE

Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973

CAPGRAS SYNDROME

A case of Capgras syndrome, MT Haslam, 493–494, April 1973
Communicative meaning in Capgras snydrome (Ltr to Ed), JA Moskowitz, 1297, Nov 1973

CEREBROSPINAL FLUID

Cerebrospinal fluid amine metabolites in affective illness: the probenecid technique, FK Goodwin, RM Post, DL Dunner, EK Gordon, 73–79, Jan 1973
Psychomotor activity and cerebrospinal fluid amine metabolites in affective illness, RM Post, J Kotin, FK Goodwin, EK Gordon, 67–72, Jan 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973

CHILDREN

Biochemical aspects of sensitivity reactions (Ltr to Ed), MP Chinoy, 1402, Dec 1973
Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973
Children's reactions to temporary loss of the father, FE Crumley, RS Blumenthal, 778–782, July 1973
The concept of child advocacy, JF McDermott Jr, WM Bolman, AM Arensdorf, RA Markoff, 1203–1206, Nov 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RM Whitman, 442–445, April 1973
The current status of child psychiatry (Editorial), SM Finch, 799–800, July 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Evidence for polygenetic inheritance in the hyperactive child syndrome, JR Morrison, MA Stewart, 791–792, July 1973
Historical background in children with affective disorders, DH McKnew Jr, L Cytryn, 1278–1280, Nov 1973
Hyperkinetic children and the Staccato syndrome (Ltr to Ed), L Tec, 330, Mar 1973
Imipramine therapy and seizures: three children treated for hyperactive behavior disorders, D Brown, BG Winsberg, I Bialer, M Press, 210–212, Feb 1973
Indian education: a human systems analysis, CA Hammerschlag, CP Alderfer, D Berg, 1098–1102, Oct 1973
Later psychosocial sequelae of early childhood illness (severe croup), JJ Sigal, L Chagoya, C Villeneuve, J Mayerovitch, 786–789, July 1973
Learning disabilities: an overview, LJ Thompson, 393–399, April 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
The life course of children with schizophrenia, L Bender, 783–786, July 1973
On "maturational lag" (Ltr to Ed), B Pasamanick, and reply of LJ Thompson, 1398–1399, Dec 1973
Pediatric-child psychiatry collaboration in a health maintenance organization, N Garber, 1227–1231, Nov 1973
Playroom setting for diagnostic family interviews, IN Orgun, 540–542, May 1973
Postgraduate training in child psychiatry: the content of the curriculum, BGB Brooks, 491–493, April 1973
Psychiatric consultations in a children's hospital, EP Monnelly, BM Ianzito, MA Stewart, 789–790, July 1973
Residential treatment: should it be concomitant with family therapy? (Ltr to Ed), DB Rinsley, and reply of PM Fine, 721, June 1973
Sensitivity reaction to imipramine (Ltr to Ed), WS Ryback, PA Jorgensen, SE Jorgensen, 940, Aug 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973
Steps in the return to school of children with school phobia, E Lassers, R Nordan, S Bladholm, 265–268, Mar 1973
Teenage helper: a role in community mental health, GA Rogeness, RA Bednar, 933–936, Aug 1973
Testing for mental retardation: comments on standard deviations (Ltr to Ed), RH Ingwell, and reply of J Wortis, 496, April 1973
Video feedback in treating hyperkinetic children: a preliminary report, S Furman, A Feighner, 792–796, July 1973
Youth psychopathology and family process research, L Hollander, E Karp, 814–817, July 1973

CHLORDIAZEPOXIDE

Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1381–1382, Dec 1973

CHLOROTHIAZIDE

Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973

CHLORPROMAZINE

Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973
Chlorpromazine contraindicated in delirium tremens (Ltrs to Ed), R Kalda and GA Rogers, and reply of JL Chapel, 1042–1043, Sept 1973
Depot phenothiazine treatment in acute psychosis: a sequential comparative clinical study, C-p Chien, JO Cole, 13–18, Jan 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, TA Hamid, WJ Wertz, 689–692, June 1973
Piperacetazine and chlorpromazine: a comparison, AC Johnson, AS Kulkarni, 603–605, May 1973

COLLEGE MENTAL HEALTH

Chronic marijuana use and psychosocial adaptation, JS Hochman, NQ Brill, and discussion by TC Rodgers, 132–140, Feb 1973
A comment on the "amotivational syndrome" in marijuana smokers, DJ Kupfer, T Detre, J Koral, P Fajans, 1319–1322, Dec 1973
Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
Marijuana and other drug use by women college students: associated risk taking and coping activities, BA Rouse, JA Ewing, and discussion by GS Glass, 486–491, April 1973
Motivational factors in abortion patients, FJ Kane Jr, PA Lachenbruch, MA Lipton, D Baram, 290–293, Mar 1973
Position statement on college mental health (Off Acts), 740, June 1973
A year's experience in student mental health at West Point, RC U'Ren, FE Conrad, PH Patterson, 643–647, June 1973

COMMUNITY PSYCHIATRY

Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
Collaborative provision of aftercare services, RM Prince Jr, RE Ackerman, BS Barksdale, 930–932, Aug 1973
Community mental health services in Britain, D Bennett, 1065–1070, Oct 1973
A comprehensive alcoholism program in the Army, BG Fiman, DR Conner, AC Segal, 532–535, May 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RM Whitman, 442–445, April 1973
A criterion approach to patient care evaluation, GL Tischler, DC Riedel, 913–919, Aug 1973
Current strains for mental health trainees, CB Brenneis, D Laub, 41–45, Jan 1973
Dumping of patients: funding and statistics a problem (Ltr to Ed), HM Kase, 111, Jan 1973
The Euclid House: a therapeutic halfway house for prisoners, SL Aledort, M Jones, 286–289, Mar 1973
Landlord-supervised cooperative apartments: a new modality for community-based treatment, C-p Chien, JO Cole, 156–159, Feb 1973
A law enforcement training program in a mental health center catchment area, EJ Rolde, E Fersch, FJ Kelly, S Frank, M Guberman, 1002–1005, Sept 1973
The nonpsychotic organic brain syndrome, B Feldshuh, J Sillen, B Parker, W Frosch, 1026–1029, Sept 1973
On the stresses of community psychiatry, and helping residents to survive them, AP Morrison, MF Shore, J Grobman, 1237–1241, Nov 1973
Position statement on community mental health centers (Off Acts), 239–240, Feb 1973

The private practice of community psychiatry, WT Vaughan Jr, DE Newman, A Levy, S Marty, 24–27, Jan 1973
Psychiatrists in the ghetto (Ltr to Ed), PA Roemer, and reply of WM Bolman, 720, June 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
A survey of attitudes of chairmen of departments of psychiatry toward community mental health, AF Panzetta, RB Sloane, H Aronson, 175–178, Feb 1973
Teenage helper: a role in community mental health, GA Rogeness, RA Bednar, 933–936, Aug 1973
A unified system of care: blueprint for the future, A Beigel, WH Bower, AI Levenson, 554–558, May 1973

COMPUTERS

Computer assignment of psychotropic drugs, IW Sletten, H Altman, RC Evenson, DW Cho, 595–598, May 1973
A computer interview for suicide-risk prediction, JH Greist, DH Gustafson, FF Stauss, GL Rowse, TP Laughren, JA Chiles, 1327–1332, Dec 1973
Factors in the description and grouping of alcoholics, RC Evenson, H Altman, IW Sletten, RR Knowles, and discussion by EM Caffey Jr, 49–54, Jan 1973
Measuring responses during treatment (Ltr to Ed), HA Lewis, 1403, Dec 1973
Phases of psychopathology after assassination, JC Finney, DE Skeeters, CD Auvenshine, DF Smith, 1379–1380, Dec 1973

CONCENTRATION CAMP EXPERIENCE

Manifestations of concentration camp effects on the second generation, HA Barocas, CB Barocas, 820–821, July 1973

CONFIDENTIALITY

Peer review: prospects and problems, DG Langsley, 301–304, Mar 1973
Position statement on the confidentiality of medical research records (Off Acts), 739, June 1973
Position statement on peer review in psychiatry (Off Acts), 381–385, Mar 1973

CONSULTATION, PSYCHIATRIC

Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
Psychiatric consultations in a children's hospital, EP Monnelly, BM Ianzito, MA Stewart, 789–790, July 1973
Psychiatric factors in security screening, L Linn, 648–652, June 1973
Steps in the return to school of children with school phobia, E Lassers, R Nordan, S Bladholm, 265–268, Mar 1973
Telepsychiatry: psychiatric consultation by interactive television, TF Dwyer, 865–869, Aug 1973

CORONARY DISEASE

Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, LR Loeb, S Peal, FF Loeb Jr, B Templeton, 160–164, Feb 1973
Subjects' recent life changes and coronary heart disease in Finland, RH Rahe, L Bennett, M Romo, P Siltanen, RJ Arthur, 1222–1226, Nov 1973

CORRESPONDENCE CONCERNING BOOK REVIEWS

Freud and the Americans (Ltr to Ed), P Rubinton, and reply of RR Grinker Sr, 1044, Sept 1973
Residential treatment: should it be concomitant with family therapy? (Ltr to Ed), DB Rinsley, and reply of PM Fine, 721, June 1973
Review reviewed (Ltr to Ed), JH Masserman, and reply of DD Swenson, 327–328, Mar 1973

COUNTERTRANSFERENCE

Countertransference reactions to violent patients, JR Lion, SA Pasternak, 207–210, Feb 1973

CRISIS INTERVENTION

Brief hospitalization on a crisis service: a study of patient and treatment variables, WR Walker, LB Parsons, WD Skelton, 896–900, Aug 1973
Emergency psychiatric hospitalization via court order: a critique, J Zusman, S Shaffer, 1323–1326, Dec 1973
An overview of crisis intervention in the emergency rooms of general hospitals, G Bartolucci, CS Drayer, 953–960, Sept 1973
Referral failures: a one-year follow-up, WA Chameides, J Yamamoto, 1157–1158, Oct 1973
A study of prediction and outcome in a mental health crisis clinic, LA Gottschalk, RA Fox, DE Bates, 1107–1111, Oct 1973
The therapeutic utilization of the juvenile court, Y Nir, R Cutler, 1112–1117, Oct 1973

DEATH AND DYING

Phenothiazine deaths: a critical review, R Peele, IS von Loetzen, 306–309, Mar 1973
Teaching psychiatry in the context of dying and death, D Barton, 1290–1291, Nov 1973

DELIVERY OF SERVICES

Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RM Whitman, 442–445, April 1973
The effect of financing on psychiatric care, RW Gibson, 299–301, Mar 1973
Goal-attainment scaling as a method for evaluating mental health programs, DW Cline, DL Rouzer, D Bransford, 105–108, Jan 1973
Learning disabilities: an overview, LJ Thompson, 393–399, April 1973
An overview of crisis intervention in the emergency rooms of general hospitals, G Bartolucci, CS Drayer, 953–960, Sept 1973
Pediatric-child psychiatry collaboration in a health maintenance organization, N Garber, 1227–1231, Nov 1973
The private practice of community psychiatry, WT Vaughan Jr, DE Newman, A Levy, S Marty, 24–27, Jan 1973
Social systems and the criteria of health as defined by the World Health Organization, A Jus, 125–131, Feb 1973
Telepsychiatry: psychiatric consultation by interactive television, TF Dwyer, 865–869, Aug 1973
A unified system of care: blueprint for the future, A Beigel, WH Bower, AI Levenson, 554–558, May 1973
What is psychiatry? a new model of service and education, AZ Guiora, SI Harrison, 1275–1277, Nov 1973

DEPERSONALIZATION

Depersonalization, dysphoria, and thought disturbance, GJ Tucker, M Harrow, D Quinlan, 702–706, June 1973

DEVELOPMENTAL PSYCHOLOGY

The behavior of chimpanzees in their natural habitat, J Van Lawick-

Goodall, 1–12, Jan 1973
Children's reactions to temporary loss of the father, FE Crumley, RS Blumenthal, 778–782, July 1973
The concept of child advocacy, JF McDermott Jr, WM Bolman, AM Arensdorf, RA Markoff, 1203–1206, Nov 1973
Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, HM Adler, VBO Hammett, 861–864, Aug 1973
The dream-protein hypothesis, EL Rossi, 1094–1097, Oct 1973
Early childhood illness and choosing the medical profession (Ltr to Ed), R Weingarten, 1295, Nov 1973
Historical background in children with affective disorders, DH McKnew Jr, L Cytryn, 1278–1280, Nov 1973
Learning disabilities: an overview, LJ Thompson, 393–399, April 1973
Marriage, family, and parenthood, H Greenbaum, 1262–1265, Nov 1973
On "maturational lag" (Ltr to Ed), B Pasamanick, and reply of LJ Thompson, 1398–1399, Dec 1973
Overview: the impact of new advances in sex research on psychoanalytic theory, RJ Stoller, 241–251, Mar 1973
Pediatric-child psychiatry collaboration in a health maintenance organization, N Garber, 1227–1231, Nov 1973
Schizophrenia: a family's projective identification, JR Stabenau, 19–23, Jan 1973
The volunteer rescue squad: the impact of a group on the psychological adaptation of its members, GW Keating, WA Brown, K Standley, 278–282, Mar 1973

DIABETES

Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973
Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, LR Loeb, S Peal, FF Loeb Jr, B Templeton, 160–164, Feb 1973

DIAGNOSIS

Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Confusion about schizophrenia (Ltr to Ed), AS Yusin, 1400, Dec 1973
Contradictions in the alcoholism criteria (Ltr to Ed), EF Kal, and reply of FA Seixas, 606, May 1973
Depersonalization, dysphoria, and thought disturbance, GJ Tucker, M Harrow, D Quinlan, 702–706, June 1973
The diagnostic decision-making process: factors influencing diagnosis and changes in diagnosis, DJ Fitzgibbons, DT Hokanson, 972–975, Sept 1973
Learning disabilities: an overview, LJ Thompson, 393–399, April 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Playroom setting for diagnostic family interviews, IN Orgun, 540–542, May 1973
Psychiatric screening with automated multiphasic health testing in the VA admission procedure, RE Gordon, L Bielen, A Watts, 46–48, Jan 1973
Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, MK El-Yousef, DS Janowsky, JM Davis, HJ Sekerke, 141–145, Feb 1973
A symposium: should homosexuality be in the APA nomenclature? RJ Stoller, J Marmor, I Bieber, R Gold, CW Socarides, R Green, RL Spitzer, 1207–1216, Nov 1973

DIAZEPAM

Drug dosage in ECT (Ltrs to Ed), M Simonson, DF Wehlage, PH Blachly, and DJ Impastato, and reply of CH Thigpen, 1293–1294, Nov 1973

DIMETHYLTRYPTAMINE

The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
A dimethyltryptamine-forming enzyme in human blood, RJ Wyatt, JM Saavedra, J Axelrod, 754–760, July 1973

DIPHENYLHYDANTOIN

Behavioral-gluco-dysrythmic triad (Ltr to Ed), JA Yaryura-Tobias, 825, July 1973
Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1281–1282, Dec 1973

DISULFIRAM

Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973

DOXEPIN

Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, C-p Chien, BA Stotsky, JO Cole, 543–548, May 1973

DREAM THEORY

The dream-protein hypothesis, EL Rossi, 1094–1097, Oct 1973
Dreams as a prognostic factor in alcoholism, SY Choi, 699–702, June 1973
Journal's culpa? (Ltr to Ed), JC Travis, and reply of Z Giora, 328, Mar 1973

DRUG DEPENDENCE

Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, EP Nace, AL Meyers, JM Rothberg, 1242–1245, Nov 1973
Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973
Are methadone withdrawal patients overprotected? (Ltr to Ed), H Asher, 1041–1042, Sept 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
Evolving behavior in the clinical and experimental amphetamine (model) psychosis, EH Ellinwood Jr, A Sudilovsky, LM Nelson, 1088–1093, Oct 1973
Hyperkinetic children and the Staccato syndrome (Ltr to Ed), L Tec, 330, Mar 1973
Imipramine withdrawal: an akathisia-like syndrome, GL Sathananthan, S Gershon, 1286–1287, Nov 1973
Legal and illegal use of methadone: one year later, RC Stephens, RS Weppner, 1391–1394, Dec 1973
Personality characteristics of servicemen returned from Viet Nam identified as heroin abusers, PT Hampton, DB Vogel, 1031–1032, Sept 1973
Quaalude alley: a one-way street, TP Bridge, EH Ellinwood Jr, 217–219, Feb 1973
Use of alcohol by addict and nonaddict populations, BS Brown, NJ Kozel, MB Meyers, RL DuPont, 599–601, May 1973

DRUG EDUCATION

Effectiveness of drug education programs for secondary school students, SC Weaver, FS Tennant Jr, 812–814, July 1973

DRUG FLASHBACKS

Marijuana flashbacks (Ltrs to Ed), AR Favazza and FE Anderson, and reply of MD Stanton, 1399–1400, Dec 1973

DRUG SIDE EFFECTS

Biochemical aspects of sensitivity reactions (Ltr to Ed), MP Chinoy, 1402, Dec 1973
Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, HM van Praag, LCW Dols, 801–804, July 1973
Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973
Is tardive dyskinesia a drug effect? (Ltr to Ed), GE Crane, and reply of JP Curran, 1043–1044, Sept 1973
Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973
Lithium-induced folliculitis, A Rifkin, SB Kurtin, F Quitkin, DF Klein, 1018–1019, Sept 1973
Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, H Kazamatsuri, C-p Chien, JO Cole, 479–483, April 1973
Management of tardive dyskinesia with thiopropazate, JP Curran, 925–927, Aug 1973
Methylphenidate in tardive dyskinesia, WE Fann, JM Davis, IC Wilson, 922–924, Aug 1973
The pharmacology of tardive dyskinesias, HL Klawans Jr, 82–86, Jan 1973
Rapid control of psychotic excitement states with intramuscular haloperidol, F SanGiovanni, MA Taylor, R Abrams, P Gaztanaga, 1155–1156, Oct 1973
Rapid reversal of tardive dyskinesia (Ltr to Ed), GE Crane, 1159, Oct 1973
Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, MK El-Yousef, DS Janowsky, JM Davis, HJ Sekerke, 141–145, Feb 1973
Sensitivity reaction to imipramine (Ltr to Ed), WS Ryback, PA Jorgensen, SE Jorgensen, 940, Aug 1973
Tardive dyskinesia and low dosage (Ltr to Ed), WE Thornton, BP Thornton, 1401, Dec 1973
Tardive dyskinesia: side effect or not? JP Curran, 406–410, April 1973
Usual and unusual agranulocytosis during neuroleptic therapy, JV Ananth, JV Valles, JP Whitelaw, 100–102, Jan 1973

DRUG STUDY

Depot phenothiazine treatment in acute psychosis: a sequential comparative clinical study, C-p Chien, JO Cole, 13–18, Jan 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, HM van Praag, LCW Dols, 801–804, July 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, H Kazamatsuri, C-p Chien, JO Cole, 479–483, April 1973
Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, TA Hamid, WJ Wertz, 689–692, June 1973
Methylphenidate in tardive dyskinesia, WE Fann, JM Davis, IC Wilson, 922–924, Aug 1973
Parkinsonism, L-dopa, and intelligence, AW Loranger, H Goodell, FH McDowell, JE Lee, RD Sweet, 1386–1389, Dec 1973
Piperacetazine and chlorpromazine: a comparison, AC Johnson, AS Kulkarni, 603–605, May 1973
Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1381–1382, Dec 1973
Rapid control of psychotic excitement states with intramuscular haloperidol, F SanGiovanni, MA Taylor, R Abrams, P Gaztanaga, 1155–1156, Oct 1973
Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, MK El-Yousef, DS Janowsky, JM Davis, HJ Sekerke, 141–145, Feb 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973
Single versus divided daily dose of trimipramine in the treatment of depressive illness, MZ Hussain, ZA Chaudhry, 1142–1144, Oct 1973
The treatment of depression with a single daily dose of imipramine pamoate, J Mendels, J DiGiacomo, 1022–1024, Sept 1973
The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness, F Stallone, E Shelley, J Mendlewicz, RR Fieve, 1006–1010, Sept 1973

DRUG TREATMENT PROGRAMS

Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, EP Nace, AL Meyers, JM Rothberg, 1242–1245, Nov 1973
Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973
Are methadone withdrawal patients overprotected? (Ltr to Ed), H Asher, 1041–1042, Sept 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
Legal and illegal use of methadone: one year later, RC Stephens, RS Weppner, 1391–1394, Dec 1973
Legal services as a tool in treating the addict, J Lowinson, J Langrod, L Alperin, 592–595, May 1973

DRUG USAGE

Chronic marijuana use and psychosocial adaptation, JS Hochman, NQ Brill, and discussion by TC Rodgers, 132–140, Feb 1973
A comment on the "amotivational syndrome" in marijuana smokers, DJ Kupfer, T Detre, J Koral, P Fajans, 1319–1322, Dec 1973
Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
Effectiveness of drug education programs for secondary school students, SC Weaver, FS Tennant Jr, 812–814, July 1973
Marijuana and other drug use by women college students: associated risk taking and coping activities, BA Rouse, JA Ewing, and discussion by GS Glass, 486–491, April 1973
Methaqualone as aphrodisiac (Ltr to Ed), S Kramer, 1044, Sept 1973
Patterns of drug abuse among military inductees, JP Callan, CD Patterson, 260–264, Mar 1973
Popular attitudes and beliefs about tranquilizers, DI Manheimer, ST Davidson, MB Balter, GD Mellinger, IH Cisin, HJ Parry, 1246–1253, Nov 1973
Psychiatric assessment of 30 chronic users of cannabis and 30 matched controls, MH Beaubrun, F Knight, 309–311, Mar 1973
The relationship between background and extent of heroin use, SF Bucky, 709–710, June 1973

ECT

Ataractic drugs versus ECT in schizophrenia (Ltr to Ed), J Spensley, and reply of LG Murillo, JE Exner Jr, 1162–1163, Oct 1973
Drug dosage in ECT (Ltrs to Ed), M Simonson, DF Wehlage, PH Blachly, and DJ Impastato, and reply of CH Thigpen, 1293–1294, Nov 1973

The effects of regressive ECT with process schizophrenics, LG Murillo, JE Exner Jr, 269–273, Mar 1973
Succinylcholine in EST (Ltr to Ed), CH Thigpen, 722, June 1973
Tardive dyskinesia: side effect or not? JP Curran, 406–410, April 1973

EDUCATION, PSYCHIATRIC

Activist and traditionalist approaches in psychiatry (Ltr to Ed), W Reich, and reply of CB Brenneis, D Laub, 825–826, July 1973
Assessing self-assessment (Ltrs to Ed), M Malcolm and HL Newbold, and reply of HT Carmichael, 1161–1162, Oct 1973
Biological psychiatry (Editorial), JM Davis, 87–88, Jan 1973
Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
"Credentials consciousness": stimulus for continuing education and peer review in psychiatry, DH Naftulin, 653–657, June 1973
The crisis of financing residency training in psychiatry: a diagnosis (Ltr to Ed), RS Daniels, 496–497, April 1973
Current strains for mental health trainees, CB Brenneis, D Laub, 41–45, Jan 1973
Designing an experientially based continuing education program, WH Barber, HJ Lurie, 1148–1150, Oct 1973
Educating the scientist-physician (Ltr to Ed), S Lipper, 1402, Dec 1973
Evaluation of the SAID teaching program, DW Cline, JN Garrard, 582–585, May 1973
Foreign medical graduates: a symposium, MH Miller, F Workneh, DJ Lewis, T-y Lin, and discussion by L Ganser, B Holland, J Smith e Incas, W Shervington, JS Steinberg, CH Fellner, 435–441, April 1973
The funding crisis: an opportunity for growth (Ltr to Ed), JM Scanlan, T Rodgers, IM Hilliard, WB Carter, TH Billingsley, T Foster, AA Axelson, 823, July 1973
The future of psychiatric education, LJ West, 521–528, May 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
Goal-attainment scaling as a method for evaluating mental health programs, DW Cline, DL Rouzer, D Bransford, 105–108, Jan 1973
Group psychotherapy supervision and its effect on resident training, WK Grossman, E Karmiol, 920–921, Aug 1973
How success nearly wrecked a residency experience, FM Kline, 1038–1040, Sept 1973
Implications of the women's liberation movement for psychotherapy, JK Rice, DG Rice, 191–196, Feb 1973
Internship for psychiatrists (Ltr to Ed), AM Varela, 1295–1296, Nov 1973
A medical interviewing course: objectives, techniques, and assessment, DW Cline, JN Garrard, 574–578, May 1973
Medical students view clinical psychiatry, SL Werkman, S Landau, H Wakefield, 562–565, May 1973
Medicine: a career conflict for women, MT Notman, CC Nadelson, and discussion by CB Wilbur, 1123–1127, Oct 1973
Motivation for medicine in the seventies, JF McDermott Jr, WF Char, MJ Hansen, 252–256, Mar 1973
A new framework for baccalaureate careers in the human services, RM Vidaver, JE Carson, 474–478, April 1973
On the stresses of community psychiatry, and helping residents to survive them, AP Morrison, MF Shore, J Grobman, 1237–1241, Nov 1973
Participatory management in psychiatry, DE Raskin, 219–221, Feb 1973
Patterns of professional activities of psychiatrists: a follow-up of 100 psychiatric residents, FK Garetz, RW Anderson, 981–984, Sept 1973
Postgraduate training in child psychiatry: the content of the curriculum, BGB Brooks, 491–493, April 1973
Psychiatric residents: a survey of training needs, satisfactions, and social attitudes, FE Fried, EG Doherty, L Coyne, 1342–1345, Dec 1973
Psychiatry in the functionally organized undergraduate curriculum, RE Becker, RM Wintrob, R Cancro, JR Stabenau, 571–574, May 1973
Psychiatry in the undergraduate medical curriculum, MD Reiser, 565–567, May 1973
Psychiatry in undergraduate medical education (Editorial), RE Becker, 586–587, May 1973
Psychiatry residents as college teachers: an evaluation of a training for teaching program, AM Lazerson, 658–662, June 1973
The requirements of a psychiatric residency program circa 1972, H Langee, ID Glick, B Hoffman, LB Silver, AP Morrison, 1151–1152, Oct 1973
The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), JC Beck, M Braun, NQ Brill, JS Eaton Jr, KE Godfrey, KH Gruberg, JA Kindwall, B Kuhner, B Liptzin, RT London, JL Mathis, AE Penetrante, AR Sorvino, HM Voth, and A Werner, and reply of GL Engel, 223–227, Feb 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
Suicide and psychiatric education, WA Kelly Jr, 463–468, April 1973
A survey of attitudes of chairmen of departments of psychiatry toward community mental health, AF Panzetta, RB Sloane, H Aronson, 175–178, Feb 1973
Teaching communication skills in medical school, J Waldron, 579–581, May 1973
The teaching of psychiatry to medical students, J Romano, 559–562, May 1973
Teaching psychiatry in the context of dying and death, D Barton, 1290–1291, Nov 1973
A test of clinical learning by medical students, RJ Thurnblad, H Muslin, J Loesch, 568–570, May 1973
Training the woman resident to be a psychiatrist, EP Benedek, 1131–1135, Oct 1973
Voluntary faculty in psychiatric education (Ltr to Ed), J Berger, 823–824, July 1973
Western humanism, modern liberal politics, and psychiatric training: friends or foes? AJ Mandell, 529–531, May 1973
What is psychiatry? a new model of service and education, AZ Guiora, SI Harrison, 1275–1277, Nov 1973
Women in psychiatry: past and present areas of concern, NA Roeske, 1127–1131, Oct 1973
Women psychiatrists in the United States, M Scher, 1118–1122, Oct 1973

EEG

Behavioral-gluco-dysrhythmic triad (Ltr to Ed), JA Yaryura-Tobías, 825, July 1973
Interaction of hypnotic suggestion and alpha enhancement, TA Travis, CY Kondo, JR Knott, 1389–1391, Dec 1973
Once more: the inaccuracy of non-EEG estimations of sleep, BL Weiss, RJ McPartland, DJ Kupfer, 1282–1285, Nov 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973

EPIDEMIOLOGY

Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, EP Nace, AL Meyers, JM Rothberg, 1242–1245, Nov 1973
Basic research and suicide prevention (Ltr to Ed), D Lester, 1402–1403, Dec 1973
Epidemiological differences between white and nonwhite suicide attempters, AM Pederson, GA Awad, AR Kindler, 1071–1076, Oct 1973
Epidemiological studies of women prisoners, I: medical and psychiatric variables related to violent behavior, CE Climent, A Rollins, FR Ervin, R Plutchik, 985–990, Sept 1973
Subjects' recent life changes and coronary heart disease in Finland, RH Rahe, L Bennett, M Romo, P Siltanen, RJ Arthur, 1222–1226, Nov 1973
Suicidal behavior in Edinburgh and Seattle, HS Ripley, 995–1001, Sept 1973

ETHICS

Broken promises (Ltr to Ed), J Betwee, 1163, Oct 1973
Physicians and the new sexual freedom, I Siassi, M Thomas, 1256–1257, Nov 1973
The Principles of Medical Ethics with annotations especially applicable to psychiatry (Off Acts), 1057–1064, Sept 1973
A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients, SH Kardener, M Fuller, IN Mensh, 1077–1081, Oct 1973
True and false experts: a second look, DS Werman, 1351–1354, Dec 1973
Truth, honesty, and the therapeutic process, L Salzman, 1280–1282, Nov 1973

FAMILY PROCESSES

Children's reactions to temporary loss of the father, FE Crumley, RS Blumenthal, 778–782, July 1973
Family structure in three cases of anorexia nervosa: the role of the father, P Wold, 1394–1397, Dec 1973
Functions of the lower-class partial family, PL Adams, 200–203, Feb 1973
Historical background in children with affective disorders, DH McKnew Jr, L Cytryn, 1278–1280, Nov 1973
Later psychosocial sequelae of early childhood illness (severe croup), JJ Sigal, L Chagoya, C Villeneuve, J Mayerovitch, 786–789, July 1973
Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
Manifestations of concentration camp effects on the second generation, HA Barocas, CB Barocas, 820–821, July 1973
Marriage, family, and parenthood, H Greenbaum, 1262–1265, Nov 1973
Playroom setting for diagnostic family interviews, IN Orgun, 540–542, May 1973
The psychiatrist and family planning (Editorial), EB Brody, 1273–1274, Nov 1973
Residential treatment: should it be concomitant with family therapy? (Ltr to Ed), DB Rinsley, and reply of PM Fine, 721, June 1973
Schizophrenia: a family's projective identification, JR Stabenau, 19–23, Jan 1973
Steps in the return to school of children with school phobia, E Lassers, R Nordan, S Bladholm, 265–268, Mar 1973
Video feedback in treating hyperkinetic children: a preliminary report, S Furman, A Feighner, 792–796, July 1973
Youth psychopathology and family process research, L Hollander, E Karp, 814–817, July 1973

FLUPHENAZINE

Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, HM van Praag, LCW Dols, 801–804, July 1973

FOLLICULITIS

Lithium-induced folliculitis, A Rifkin, SB Kurtin, F Quitkin, DF Klein, 1018–1019, Sept 1973

FOLLOW-UP STUDIES

Follow-up on Baxstrom patients returned to hospitals for the criminally insane, HJ Steadman, 317–319, Mar 1973
Goal-attainment scaling as a method for evaluating mental health programs, DW Cline, DL Rouzer, D Bransford, 105–108, Jan 1973
The life course of children with schizophrenia, L Bender, 783–786, July 1973
Referral failures: a one-year follow-up, WA Chameides, J Yamamoto, 1157–1158, Oct 1973
Therapeutic abortion and a prior psychiatric history, JA Ewing, BA Rouse, 37–40, Jan 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973

FOREIGN MEDICAL GRADUATES

Cheap labor from poor nations, EF Torrey, RL Taylor, and discussion by R Cserr, 428–434, April 1973
Foreign medical graduates: a symposium, MH Miller, F Workneh, EB Brody, DJ Lewis, T-y Lin, and discussion by L Ganser, B Holland, J Smith e Incas, W Shervington, JS Steinberg, CH Fellner, 435–441, April 1973
Psychiatric residents: a survey of training needs, satisfactions, and social attitudes, FE Fried, EG Doherty, L Coyne, 1342–1345, Dec 1973

FORENSIC PSYCHIATRY

Amnesia and competency to stand trial, D Koson, A Robey, and discussion by LC Maguigad, 588–592, May 1973
"Dying with their rights on" (Ltr to Ed), DA Treffert, 1041, Sept 1973
Emergency psychiatric hospitalization via court order: a critique, J Zusman, S Shaffer, 1323–1326, Dec 1973
Epidemiological studies of women prisoners, I: medical and psychiatric variables related to violent behavior, CE Climent, A Rollins, FR Ervin, R Plutchik, 985–990, Sept 1973
The Euclid House: a therapeutic halfway house for prisioners, SL Aledort, M Jones, 286–289, Mar 1973
Factors affecting referral to determine competency to stand trial, G Cooke, N Johnston, E Pogany, 870–875, Aug 1973
"The fitness factory," part I: the psychiatrist's role in determining competency, RL Goldstein, 1144–1147, Oct 1973
Follow-up on Baxstrom patients returned to hospitals for the criminally insane, HJ Steadman, 317–319, Mar 1973
Incompetency to stand trial: is psychiatry necessary? RH Bendt, EJ Balcanoff, GS Tragellis, 1288–1289, Nov 1973
A law enforcement training program in a mental health center catchment area, EJ Rolde, E Fersch, FJ Kelly, S Frank, M Guberman, 1002–1005, Sept 1973
Legal services as a tool in treating the addict, J Lowinson, J Langrod, L Alperin, 592–595, May 1973
Overview: current trends in mental health law, AL McGarry, HA Kaplan, 621–630, June 1973
Phases of psychopathology after assassination, JC Finney, DE Skeeters, CD Auvenshine, DF Smith, 1379–1380, Dec 1973
A proposed "dangerous sex offender" law, NT Sidley, FJ Stolarz, 765–768, July 1973
The therapeutic utilization of the juvenile court, Y Nir, R Cutler, 1112–1117, Oct 1973
True and false experts: a second look, DS Werman, 1351–1354, Dec 1973
The writ writer, MF Cleary, 319–322, Mar 1973

GENERAL PSYCHIATRY

About psychiatry, psychiatrists, and social problems (Editorial), VW Bernard, 204–205, Feb 1973
Biological psychiatry (Editorial), JM Davis, 87–88, Jan 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, HM Adler, VBO Hammett, 861–864, Aug 1973
Current strains for mental health trainees, CB Brenneis, D Laub, 41–45, Jan 1973
Early childhood illness and choosing the medical profession (Ltr to Ed), R Weingarten, 1295, Nov 1973

The effect of financing on psychiatric care, RW Gibson, 299–301, Mar 1973
The future of psychiatric education, LJ West, 521–528, May 1973
Medicine: a career conflict for women, MT Notman, CC Nadelson, and discussion by CB Wilbur, 1123–1127, Oct 1973
Motivation for medicine in the seventies, JF McDermott Jr, WF Char, MJ Hansen, 252–256, Mar 1973
An overview of trends in psychiatric research: 1963–1972, HKH Brodie, M Sabshin, 1309–1318, Dec 1973
Patterns of professional activities of psychiatrists: follow-up of 100 psychiatric residents, FK Garetz, RW Anderson, 981–984, Sept 1973
Peer review: prospects and problems, DG Langsley, 301–304, Mar 1973
Psychiatry and neurology (Ltr to Ed), EC Dorsey, 110–111, Jan 1973
Psychiatry in the undergraduate medical curriculum, MF Reiser, 565–567, May 1973
Psychiatry in undergraduate medical education (Editorial), RE Becker, 586–587, May 1973
The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), JC Beck, M Braun, NQ Brill, JS Eaton Jr, KE Godfrey, KH Gruberg, JA Kindwall, B Kuhner, B Liptzin, RT London, JL Mathis, AE Penetrante, AR Sorvino, HM Voth, and A Werner, and reply of GL Engel, 223–227, Feb 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
Social systems and the criteria of health as defined by the World Health Organization, A Jus, 125–131, Feb 1973
A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients, SH Kardener, M Fuller, IN Mensh, 1077–1081, Oct 1973
Training the woman resident to be a psychiatrist, EP Benedek, 1131–1135, Oct 1973
Western humanism, modern liberal politics, and psychiatric training: friends or foes? AJ Mandell, 529–531, May 1973
What is psychiatry? a new model of service and education, AZ Guiora, SI Harrison, 1275–1277, Nov 1973
Women in psychiatry (Editorial), RZ Solomon, 1136–1137, Oct 1973
Women in psychiatry: past and present areas of concern, NA Roeske, 1127–1131, Oct 1973
Women psychiatrists in the United States, M Scher, 1118-1122, Oct 1973

GENETIC STUDIES

The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
Evidence for polygenetic inheritance in the hyperactive child syndrome, JP Morrison, MA Stewart, 791–792, July 1973
Hereditary transmission of psychiatric illness (Editorial), SB Guze, 1377–1378, Dec 1973
Manic-depressive illness: linkage with the Xg blood group, RR Fieve, J Mendlewicz, JL Fleiss, 1355–1359, Dec 1973
Relationship between the effectiveness of lithium therapy and family history, J Mendlewicz, RR Fieve, F Stallone, 1011–1013, Sept 1973
The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness, F Stallone, E Shelley, J Mendlewicz, RR Fieve, 1006–1010, Sept 1973

GERIATRIC PSYCHIATRY

Care of the chronically mentally ill—a national disgrace (Editorial), R Reich, 911–912, Aug 1973
A myth unmythed (Ltr to Ed), DP Birkett, 329, Mar 1973
The nonpsychotic organic brain syndrome, B Feldshuh, J Sillen, B Parker, W Frosch, 1026–1029, Sept 1973
Position statement on aging (Off Acts), 950–951, Aug 1973
Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, C-p Chien, BA Stotsky, JO Cole, 543–548, May 1973
The psychiatric treatment of the geriatric patient, RJ Nathan, and discussion by JH Friedman, 711–714, June 1973
The road to Shangri-La is paved with vitamins, R Bitensky, 1253–1256, Nov 1973

GROUP MEDICAL PRACTICE

Psychiatry and group medical practice: the diagnostic process, referral patterns, and utilization of services, JW Crawford, S Crawford, 637–642, June 1973

GROUP PROCESSES

The behavior of chimpanzees in their natural environment, J Van Lawick-Goodall, 1–12, Jan 1973
Designing an experientially based continuing education program, WH Barber, HJ Lurie, 1148–1150, Oct 1973
Emotional involvement in psychotherapy (Ltr to Ed), DB Gesenway, and reply of H Spotnitz, 937–939, Aug 1973
The Euclid House: a therapeutic halfway house for prisoners, SL Aledort, M Jones, 286–289, Mar 1973
Even mental health jargon can be funny (Ltr to Ed), FD Barton, 495, April 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
Group process research: a factor analytical study, DM Hawkins, CB Norton, C Eisdorfer, D Gianturco, 916–919, Aug 1973
Group psychotherapy supervision and its effect on resident training, WK Grossman, E Karmiol, 920–921, Aug 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973
The road to Shangri-La is paved with vitamins, R Bitensky, 1253–1256, Nov 1973
Time-extended group therapy sessions in a remote setting, J Reckless, D Hawkins, A Fauntleroy, 1024–1026, Sept 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973
The volunteer rescue squad: the impact of a group on the psychological adaptation of its members, GW Keating, WA Brown, K Standley, 278–282, Mar 1973

GUANETHIDINE

Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973

HALFWAY HOUSES

The Euclid House: a therapeutic halfway house for prisoners, SL Aledort, M Jones, 286–289, Mar 1973

HALLUCINOGENS

The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
A dimethyltryptamine-forming enzyme in human blood, RJ Wyatt, JM Saavedra, J Axelrod, 754–760, July 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Indian peyotists and alcohol (Ltr to Ed), C Roy, 329–330, Mar 1973
Marijuana flashbacks (Ltrs to Ed), AR Favazza and FE Anderson, and reply of MD Stanton, 1399–1400, Dec 1973
Patterns of drug abuse among military inductees, JP Callan, CD Patterson, 260–264, Mar 1973

HALOPERIDOL

Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973
Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, H Kazamatsuri, C-p Chien, JO Cole, 479–483, April 1973

Rapid control of psychotic excitement states with intramuscular haloperidol, F SanGiovanni, MA Taylor, R Abrams, P Gaztanaga, 1155–1156, Oct 1973

HEALTH INSURANCE

The effect of financing on psychiatric care, RW Gibson, 299–301, Mar 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
The private practice of community psychiatry, WT Vaughan Jr, DE Newman, A Levy, S Marty, 24–27, Jan 1973

HEALTH MAINTENANCE ORGANIZATIONS

Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
Pediatric-child psychiatry collaboration in a health maintenance organization, N Garber, 1227–1231, Nov 1973

HEMODIALYSIS

Intellectual impairment in uremic patients (Ltrs to Ed), J Yager and NB Levy, and reply of RP Greenberg, G Davis, R Massey, 1159–1161, Oct 1973
The psychological evaluation of patients for a kidney transplant and hemodialysis program, RP Greenberg, G Davis, R Massey, 274–277, Mar 1973

HEROIN

Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, EP Nace, AL Meyers, JM Rothberg, 1242–1245, Nov 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
Personality characteristics of servicemen returned from Viet Nam identified as heroin abusers, PT Hampton, DB Vogel, 1031–1032, Sept 1973
The relationship between background and extent of heroin use, SF Bucky, 709–710, June 1973

HISTORY

Benjamin Rush: morality in government (Editorial), RE Jones, 1137–1138, Oct 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, MH Adler, VBO Hammett, 861–864, Aug 1973
Freud and the Americans (Ltr to Ed), P Rubinton, and reply of RR Grinker Sr, 1044, Sept 1973
Mental health of political candidates: notes on Abraham Lincoln (Ltr to Ed), RW Hudgens, 110, Jan 1973
1973 anniversaries, G Mora, 1346–1350, Dec 1973
Some aspects of the history of Swiss psychiatry, M Bleuler, 991–994, Sept 1973
True and false experts: a second look, DS Werman, 1351–1354, Dec 1973

HOMOSEXUALITY

Sexual freedom in adolescents: a reaction formation? (Ltr to Ed), WV Hempel, 722, June 1973
A symposium: should homosexuality be in the APA nomenclature? RJ Stoller, J Marmor, I Bieber, R Gold, CW Socarides, R Green, RL Spitzer, 1207–1216, Nov 1973

HOSPITALIZATION

Brief hospitalization on a crisis service: a study of patient and treatment variables, WR Walker, LB Parsons, WD Skelton, 896–900, Aug 1973
Care of the chronically mentally ill—a national disgrace (Editorial), R Reich, 911–912, Aug 1973
Community mental health services in Britain, D Bennett, 1065–1070, Oct 1973
Dumping of patients: funding and statistics a problem (Ltr to Ed), HM Kase, 111, Jan 1973
"Dying with their rights on" (Ltr to Ed), DA Treffert, 1041, Sept 1973
The effects of social prejudice on hospitalized adolescents, PG Rossman, D Miller, 1029–1031, Sept 1973
Emergency psychiatric hospitalization via court order: a critique, J Zusman, S Shaffer, 1323–1326, Dec 1973
Empty hospital beds and human misery (Ltrs to Ed), ZM Lebensohn and JE Blank, 1401–1402, Dec 1973
Hospital treatment of borderline patients, G Adler, and discussion by OF Kernberg, 32–36, Jan 1973
Judgments of alternatives to hospitalization, SH Lipsius, and discussion by J de la Torre, 892–896, Aug 1973
The nonpsychotic organic brain syndrome, B Feldshuh, J Sillen, B Parker, W Frosch, 1026–1029, Sept 1973
An overview of crisis intervention in the emergency rooms of general hospitals, G Bartolucci, CS Drayer, 953–960, Sept 1973
Position statement on involuntary hospitalization of the mentally ill (revised) (Off Acts), 392, Mar 1973
The practice of hospital psychiatry: a formulation, GJ Tucker, JS Maxmen, 887–891, Aug 1973
Problems associated with the introduction of a psychiatric unit into a rural general hospital, S Bloomberg, 28–31, Jan 1973
Psychiatric screening with automated multiphasic health testing in the VA admission procedure, RE Gordon, L Bielen, A Watts, 46–48, Jan 1973
Relationships between length of stay in and out of the New York State mental hospitals, AS Weinstein, D DiPasquale, F Winsor, 904–909, Aug 1973
Self-destructive and suicidal behaviors in a neuropsychiatric inpatient facility, JJ Fabian, MP Maloney, MP Ward, 1383–1385, Dec 1973
A unified system of care: blueprint for the future, A Beigel, WH Bower, AI Levenson, 554–558, May 1973
Utilization review of psychiatric inpatient care, A Richman, H Pinsker, 900–903, Aug 1973

HYDROXYZINE

Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973

HYPERACUSIA

Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973

HYPERKINESIS

Biochemical aspects of sensitivity reactions (Ltr to Ed), MP Chinoy, 1402, Dec 1973
Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973

Evidence for polygenetic inheritance in the hyperactive child syndrome, JR Morrison, MA Stewart, 791–792, July 1973
Hyperkinetic children and the Staccato syndrome (Ltr to Ed), L Tec, 330, Mar 1973
Imipramine therapy and seizures: three children treated for hyperactive behavior disorders, D Brown, BG Winsberg, I Bialer, M Press, 210–212, Feb 1973
Levoamphetamine and dextroamphetamine: differential effect on aggression and hyperkinesis in children and dogs, LE Arnold, V Kirilcuk, SA Corson, E O'L Corson, 165–170, Feb 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973
Video feedback in treating hyperkinetic children: a preliminary report, S Furman, A Feighner, 792–796, July 1973

HYPNOSIS

Acupunctural analgesia: its explanation by conditioning theory, autogenic training, and hypnosis, WS Kroger, 855–860, Aug 1973
An episode of acute, self-limiting depersonalization following a first session of hypnosis, EN Wineburg, N Straker, 98–100, Jan 1973
Interaction of hypnotic suggestion and alpha enhancement, TA Travis, CY Kondo, JR Knott, 1389–1391, Dec 1973
The safety of hypnoses (Ltr to Ed), E Klemperer, and reply of EN Wineburg, N Straker, 1044–1045, Sept 1973
Surgery using hypnosis in 1845 (Ltr to Ed), MB Sell, 1402, Dec 1973

HYPOGLYCEMIA

Growth hormone and prolactin in unipolar and bipolar depressed patients: responses to hypoglycemia and L-dopa, EJ Sachar, AG Frantz, N Altman, J Sassin, 1362–1367, Dec 1973

IMIPRAMINE

Concomitant imipramine and methylphenidate administration: a case report (Ltr to Ed), TB Cooper, GM Simpson, 721, June 1973
Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973
Imipramine therapy and seizures: three children treated for hyperactive behavior disorders, D Brown, BG Winsberg, I Bialer, M Press, 210–212, Feb 1973
Imipramine withdrawal: an akathisia-like syndrome, GL Sathananthan, S Gershon, 1286–1287, Nov 1973
Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, JJ Schildkraut, 695–699, June 1973
Plasma binding of imipramine and clinical outcome, AH Glassman, MJ Hurwic, JM Perel, 1367–1369, Dec 1973
Sensitivity reaction to imipramine (Ltr to Ed), WS Ryback, PA Jorgensen, SE Jorgensen, 940, Aug 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973
The treatment of depression with a single daily dose of imipramine pamoate, J Mendels, J DiGiacomo, 1022–1024, Sept 1973

INTERPROFESSIONAL AND INTERDISCIPLINARY RELATIONSHIPS

The attitudes of patients and aides toward the role of the psychiatric aide, L Handler, G Perlman, 322–325, Mar 1973
Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
The clinical case conference reconsidered, JR McNamara, 1153–1154, Oct 1973
Collaborative provision of aftercare services, RM Prince Jr, RE Ackerman, BS Barksdale, 930–932, Aug 1973
Designing an experientially based continuing education program, WH Barber, HJ Lurie, 1148–1150, Oct 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
Epidemiological studies of women prisoners, I: medical and psychiatric variables related to violent behavior, CE Climent, A Rollins, FR Ervin, R Plutchik, 985–990, Sept 1973
The Euclid House: a therapeutic halfway house for prisoners, SL Aledort, M Jones, 286–289, Mar 1973
Hospital treatment of borderline patients, G Adler, and discussion by OF Kernberg, 32–36, Jan 1973
Joint statement on antisubstitution laws and regulations (Off Acts), 741, June 1973
A new framework for baccalaureate careers in the human services, RM Vidaver, JE Carson, 474–478, April 1973
An overview of crisis intervention in the emergency rooms of general hospitals, G Bartolucci, CS Drayer, 953–960, Sept 1973
The paraprofessional teaches the professional, JA Talbott, AM Ross, AF Skerrett, MD Curry, SI Marcus, H Theodorou, B Smith, 805–808, July 1973
Pediatric-child psychiatry collaboration in a health maintenance organization, N Garber, 1227–1231, Nov 1973
Position statement on psychiatrists' relationships with nonmedical mental health professionals (Off Acts), 386–390, Mar 1973
Problems associated with the introduction of a psychiatric unit into a rural general hospital, S Bloomberg, 28–31, Jan 1973
Psychiatry in the undergraduate medical curriculum, MF Reiser, 565–567, May 1973
What is psychiatry? a new model of service and education, AZ Guiora, SI Harrison, 1275–1277, Nov 1973

L-DOPA

Growth hormone and prolactin in unipolar and bipolar patients: responses to hypoglycemia and L-dopa, EJ Sachar, AG Frantz, N Altman, J Sassin, 1362–1367, Dec 1973
Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
L-dopa, dopamine, and hypomania, DL Murphy, FK Goodwin, HKH Brodie, WE Bunney Jr, 79–82, Jan 1973
Parkinsonism, L-dopa, and intelligence, AW Loranger, H Goodell, FH McDowell, JE Lee, RD Sweet, 1386–1389, Dec 1973

LEARNING DISABILITIES

Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
Learning disabilities: an overview, LJ Thompson, 393–399, April 1973
On "maturational lag" (Ltr to Ed), B Pasamanick, and reply of LJ Thompson, 1398–1399, Dec 1973

LITHIUM

Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973
Lithium-induced folliculitis, A Rifkin, SB Kurtin, F Quitkin, DF Klein, 1018–1019, Sept 1973
Relationship between the effectiveness of lithium therapy and family history, J Mendlewicz, RR Fieve, F Stallone, 1011–1013, Sept 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973

The 24-hour serum lithium level as a prognosticator of dosage requirements, TB Cooper, P-eE Bergner, GM Simpson, 601–603, May 1973
The use of lithium in affective disorders, III: a double-blind study of prophylaxis in bipolar illness, F Stallone, E Shelley, J Mendlewicz, RR Fieve, 1006–1010, Sept 1973

L-TRYPTOPHAN

Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973

MARIJUANA

Chronic marijuana use and psychosocial adaptation, JS Hochman, NQ Brill, and discussion by TC Rodgers, 132–140, Feb 1973
A comment on the "amotivational syndrome" in marijuana smokers, DJ Kupfer, T Detre, J Koral, P Fajans, 1319–1322, Dec 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Id-ego: synergy or antagonism? (Ltr to Ed), CF Hesselbach, and reply of TC Rodgers, 1296–1297, Nov 1973
Marijuana and amphetamine: the question of interaction, S Zalcman, B Liskow, R Cadoret, D Goodwin, 707–708, June 1973
Marijuana and other drug use by women college students: associated risk taking and coping activities, BA Rouse, JA Ewing, and discussion by GS Glass, 486–491, April 1973
Marijuana flashbacks (Ltrs to Ed), AR Favazza and FE Anderson, and reply of MD Stanton, 1399–1400, Dec 1973
Psychiatric assessment of 30 chronic users of cannabis and 30 matched controls, MH Beaubrun, F Knight, 309–311, Mar 1973

MARITAL THERAPY

Time extended group therapy sessions in a remote setting, J Reckless, D Hawkins, A Fauntleroy, 1024–1026, Sept 1973

MESCALINE

Indian peyotists and alcohol (Ltr to Ed), C Roy, 329–330, Mar 1973

MESORIDAZINE

Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, TA Hamid, WJ Wertz, 689–692, June 1973

METAPSYCHIATRY

Metapsychiatry: the interface between psychiatry and mysticism, SR Dean, 1036–1038, Sept 1973
Psyching out psi (Ltr to Ed), J Ehrenwald, 328–329, Mar 1973

METHADONE

Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973
Are methadone withdrawal patients overprotected? (Ltr to Ed), H Asher, 1041–1042, Sept 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
Legal and illegal use of methadone: one year later, RC Stephens, RC Weppner, 1391–1394, Dec 1973
Legal services as a tool in treating the addict, J Lowinson, J Langrod, L Alperin, 592–595, May 1973

METHAQUALONE

Methaqualone as aphrodisiac (Ltr to Ed), S Kramer, 1044, Sept 1973
Quaalude alley: a one-way street, TP Bridge, EH Ellinwood Jr, 217–219, Feb 1973

METHYLPHENIDATE

Antagonistic effects of physostigmine and methylphenidate in man, DS Janowsky, MK El-Yousef, JM Davis, HJ Sekerke, 1370–1376, Dec 1973
Caffeine as a substitute for schedule II stimulants in hyperkinetic children, RC Schnackenberg, 796–798, July 1973
Concomitant imipramine and methylphenidate administration: a case report (Ltr to Ed), TB Cooper, GM Simpson, 721, June 1973
Drug comparison in hyperactive children (Ltr to Ed), DJ Safer, RP Allen, and reply of LM Greenberg, MA Deem, S McMahon, 939–940, Aug 1973
Methylphenidate in tardive dyskinesia, WE Fann, JM Davis, IC Wilson, 922–924, Aug 1973
Side effects of methylphenidate (Ltr to Ed), JR Ullrich, and reply of BG Winsberg, 941–942, Aug 1973

MILIEU THERAPY

Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, HM Adler, VBO Hammett, 861–864, Aug 1973
A hospital riot: its determinants and implications for treatment, RC Marohn, D Dalle-Molle, D Offer, E Ostrov, 631–636, June 1973
The practice of hospital psychiatry: a formulation, GJ Tucker, JS Maxmen, 887–891, Aug 1973
Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, C-p Chien, BA Stotsky, JO Cole, 543–548, May 1973
The psychiatric treatment of the geriatric patient, RJ Nathan, and discussion by JH Friedman, 711–714, June 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973

MILITARY PSYCHIATRY

Addicted Viet Nam veterans: a comparison of self-referred and system-referred samples, EP Nace, AL Meyers, JM Rothberg, 1242–1245, Nov 1973
Children's reactions to temporary loss of the father, FE Crumley, RS Blumenthal, 778–782, July 1973
A comprehensive alcoholism program in the Army, BG Fiman, DR Conner, AC Segal, 532–535, May 1973
Patterns of drug abuse among military inductees, JP Callan, CD Patterson, 260–264, Mar 1973
Personality characteristics of servicemen returned from Viet Nam identified as heroin abusers, PT Hampton, DB Vogel, 1031–1032, Sept 1973
Reentry: I. "making it" back in the States, JF Borus, 850–854, Aug 1973
A year's experience in student mental health at West Point, RC U'Ren, FE Conrad, PH Patterson, 643–647, June 1973

NEUROLOGY

Psychiatry and neurology (Ltr to Ed), EC Dorsey, 110–111, Jan 1973

NUTRITIONAL THERAPY

Behavioral-gluco-dysrythmic triad (Ltr to Ed), JA Yaryura-Tobías, 825, July 1973

Effects of nutrition on schizophrenia (Ltr to Ed), GA Baker, and reply of FC Dohan, 1400–1401, Dec 1973
Relapsed schizophrenics: earlier discharge from the hospital after cereal-free, milk-free diet, FC Dohan, JC Grasberger, 685–688, June 1973

OBITUARIES

Karl Murdock Bowman, 1888–1973 (In Mem), A Simon, 717–718, June 1973
Bernard Glueck, Sr., 1884–1972 (In Mem), ZM Lebensohn, 326, Mar 1973
Eugen Kahn, 1887–1973 (In Mem), AD Pokorny, 822, July 1973
Lawrence Kolb, 1881–1972 (In Mem), RH Felix, 718–719, June 1973
Sandor Rado, 1890–1972 (In Mem), JM Cotton, 222, Feb 1973
Ludwig von Bertalanffy, 1901–1972 (In Mem), W Gray, 1292, Nov 1973

PARKINSONISM

Parkinsonism, L-dopa, and intelligence, AW Loranger, H Goodell, FH McDowell, JE Lee, RD Sweet, 1386–1389, Dec 1973
The pharmacology of tardive dyskinesias, HL Klawans Jr, 82–86, Jan 1973

PATIENT MANAGEMENT

Alcoholism among methadone patients: a specific treatment method, I Liebson, G Bigelow, R Flamer, 483–485, April 1973
Are methadone withdrawal patients overprotected? (Ltr to Ed), H Asher, 1041–1042, Sept 1973
Emergency room treatment of the drug-abusing patient, JL Chapel, 257–259, Mar 1973
Engaging heroin addicts in treatment, JA Renner, ML Rubin, 976–980, Sept 1973
A hospital riot: its determinants and implications for treatment, RC Marohn, D Dalle-Molle, D Offer, E Ostrov, 631–636, June 1973
Hospital treatment of borderline patients, G Adler, and discussion by OF Kernberg, 32–36, Jan 1973
Landlord-supervised cooperative apartments: a new modality for community-based treatment, C-p Chien, JO Cole, 156–159, Feb 1973
Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
No-suicide decisions: patient monitoring of suicidal risk, RC Drye, RL Goulding, ME Goulding, 171–174, Feb 1973
An overview of a psychiatric clinic population, PE Sifneos, 1033–1035, Sept 1973
Psychiatry with the aborigines of West Malaysia, JD Kinzie, JM Bolton, 769–773, July 1973
Religious delusions in counter-culture patients, P Levinson, 1265–1269, Nov 1973
Teaching psychiatry in the context of dying and death, D Barton, 1290–1291, Nov 1973
A therapeutic aftercare setting for "refractory" chronic schizophrenic patients, PT Donlon, RT Rada, SW Knight, 682–684, June 1973

PEER REVIEW

Assessing self-assessment (Ltrs to Ed), M Malcolm and HL Newbold, and reply of HT Carmichael, 1161–1162, Oct 1973
"Credentials consciousness": stimulus for continuing education and peer review in psychiatry, DH Naftulin, 653–657, June 1973
A criterion approach to patient care evaluation, GL Tischler, DC Riedel, 913–916, Aug 1973
If they were here now (Editorial), JM Myers, 910–911, Aug 1973
Peer review: prospects and problems, DG Langsley, 301–304, Mar 1973
Position statement on peer review (Off Acts), 381–385, Mar 1973
Utilization review of psychiatric inpatient care, A Richman, H Pinsker, 900–903, Aug 1973

PENTYLENETETRAZOL

Drug dosage in ECT (Ltrs to Ed), M Simonson, DF Wehlage, PH Blachly, and DJ Impastato, and reply of CH Thigpen, 1293–1294, Nov 1973
Succinylcholine in EST (Ltr to Ed), CH Thigpen, 722, June 1973

PERIODIC CATATONIA

Urinary cyclic AMP in periodic catatonia, TL Perry, S Hemmings, GI Drummond, S Hansen, LR Gjessing, 927–929, Aug 1973

PHARMACOTHERAPY

Ataractic drugs versus ECT in schizophrenia (Ltr to Ed), J Spensley, and reply of LG Murillo, JE Exner Jr, 1162–1163, Oct 1973
Biological psychiatry (Editorial), JM Davis, 87–88, Jan 1973
Computer assignment of psychotropic drugs, IW Sletten, H Altman, RC Evenson, DW Cho, 595–598, May 1973
Danger of depot phenothiazine treatment in acute psychosis (Ltr to Ed), JB Schoonmaker, and reply of C-p Chien, JO Cole, 722–723, June 1973
Depot phenothiazine treatment in acute psychosis: a sequential comparative clinical study, C-p Chien, JO Cole, 13–18, Jan 1973
Drug treatment of depressed patients referred for hospitalization, J Kotin, RM Post, FK Goodwin, 1139–1141, Oct 1973
The effects of regressive ECT with process schizophrenics, LG Murillo, JE Exner Jr, 269–273, Mar 1973
Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, HM van Praag, LCW Dols, 801–804, July 1973
Imipramine in hyperacusic depression (Ltr to Ed), JS Carman, 937, Aug 1973
Influence of affective states and psychoactive drugs on verbal learning and memory, GM Henry, H Weingartner, DL Murphy, and discussion by R Abrams, 966–971, Sept 1973
Management of tardive dyskinesia with thiopropazate, JP Curran, 925–927, Aug 1973
Norepinephrine metabolites as biochemical criteria for classifying depressive disorders and predicting responses to treatment: preliminary findings, JJ Schildkraut, 695–699, June 1973
Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1381–1382, Dec 1973
Psychiatric treatment for nursing home patients: drug, alcohol, and milieu, C-p Chien, JO Cole, 543–548, May 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973
Rapid control of psychotic excitement states with intramuscular haloperidol, F SanGiovanni, MA Taylor, R Abrams, P Gaztanaga, 1155–1156, Oct 1973
Relationship between the effectiveness of lithium therapy and family history, J Mendlewicz, RR Fieve, F Stallone, 1011–1013, Sept 1973
Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973
Single versus divided daily dose of trimipramine in the treatment of depressive illness, MZ Hussain, ZA Chaudhry, 1142–1144, Oct 1973
A study of prediction and outcome in a mental health crisis clinic, LA Gottschalk, RA Fox, DE Bates, 1107–1111, Oct 1973
The 24-hour serum lithium level as a prognosticator of dosage requirements, TB Cooper, P-eE Bergner, GM Simpson, 601–603, May 1973

PHENOTHIAZINES

Amphetamine psychosis: a "model" schizophrenia mediated by catecholamines, SH Snyder, 61–67, Jan 1973

Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973
A case of Capgras syndrome, MT Haslam, 493–494, April 1973
Danger of depot phenothiazine treatment in acute psychosis (Ltr to Ed), JB Schoonmaker, and reply of C-p Chien, JO Cole, 722–723, June 1973
Depot phenothiazine treatment in acute psychosis: a sequential comparative clinical study, C-p Chien, JO Cole, 13–18, Jan 1973
Effects of nutrition on schizophrenia (Ltr to Ed), GA Baker, and reply of FC Dohan, 1400–1401, Dec 1973
Fluphenazine enanthate and fluphenazine decanoate: a comparison of their duration of action and motor side effects, HM van Praag, LCW Dols, 801–804, July 1973
Is tardive dyskinesia a drug effect? (Ltr to Ed), GE Crane, and reply of JP Curran, 1043–1044, Sept 1973
Landlord-supervised cooperative apartments: a new modality for community-based treatment, C-p Chien, JO Cole, 156–159, Feb 1973
Management of tardive dyskinesia with thiopropazate, JP Curran, 925–927, Aug 1973
Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, TA Hamid, WJ Wertz, 689–692, June 1973
The pharmacology of tardive dyskinesias, HL Klawans Jr, 82–86, Jan 1973
Phenothiazine deaths: a critical review, R Peele, IS von Loetzen, 306–309, Mar 1973
Psychiatry with the aborigines of West Malaysia, JD Kinzie, JM Bolton, 769–773, July 1973
Rapid reversal of tardive dyskinesia (Ltr to Ed), GE Crane, 1159, Oct 1973
Tardive dyskinesia and low dosage (Ltr to Ed), WE Thornton, BP Thornton, 1401, Dec 1973
Tardive dyskinesia: side effect or not? JP Curran, 406–410, April 1973
Usual and unusual agranulocytosis during neuroleptic therapy, JV Ananth, JV Valles, JP Whitelaw, 100–102, Jan 1973

PHOBIAS

The eclectic approach to the treatment of phobias, KR MacKenzie, and discussion by EM Caffey Jr, 1103–1106, Oct 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973

PHYSOSTIGMINE

Antagonistic effects of physostigmine and methylphenidate in man, DS Janowsky, MK El-Yousef, JM Davis, HJ Sekerke, 1370–1376, Dec 1973
Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, MK El-Yousef, DS Janowsky, JM Davis, HJ Sekerke, 141–145, Feb 1973

PIPERACETAZINE

Piperacetazine and chlorpromazine: a comparison, AC Johnson, AS Kulkarni, 603–605, May 1973

POLYGRAPH

The polygraph in a psychiatric setting, S Abrams, 94–98, Jan 1973

POLYURIA

Lithium-induced diabetes insipidus: manic symptoms, brain and electrolyte correlates, and chlorothiazide treatment, ST Levy, JN Forrest Jr, GR Heninger, 1014–1018, Sept 1973

POSITION STATEMENTS

Joint statement on antisubstitution laws and regulations (Off Acts), 741, June 1973
Position statement on aging (Off Acts), 950–951, Aug 1973
Position statement on college mental health (Off Acts), 740, June 1973
Position statement on community mental health centers (Off Acts), 239–240, Feb 1973
Position statement on the confidentiality of medical research records (Off Acts), 739, June 1973
Position statement on homicide prevention (Off Acts), 391, Mar 1973
Position statement on involuntary hospitalization of the mentally ill (revised) (Off Acts), 392, Mar 1973
Position statement on peer review in psychiatry (Off Acts), 381–385, Mar 1973
Position statement on psychiatrists' relationships with nonmedical mental health professionals (Off Acts), 386–390, Mar 1973
The Principles of Medical Ethics with annotations especially applicable to psychiatry (Off Acts), 1057–1064, Sept 1973

PRESENILE DEMENTIA

A patient's view of presenile dementia (Ltr to Ed), H Robbins, 1294–1295, Nov 1973

PROBENECID

Cerebrospinal fluid amine metabolites in affective illness: the probenecid technique, FK Goodwin, RM Post, DL Dunner, EK Gordon, 73–79, Jan 1973

PSYCHOANALYSIS

Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, HM Adler, VBO Hammett, 861–864, Aug 1973
Emotional involvement in psychotherapy (Ltr to Ed), DB Gesenway, and reply of H Spotnitz, 937–939, Aug 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
Id-ego: synergy or antagonism? (Ltr to Ed), CF Hesselbach, and reply of TC Rodgers, 1296–1297, Nov 1973
Overview: the impact of new advances in sex research on psychoanalytic theory, RJ Stoller, 241–251, Mar 1973

PSYCHOBIOLOGY

Adolf Meyer and psychobiology (Ltr to Ed), RP Wang, 824, July 1973

PSYCHOLOGICAL AND PSYCHOMETRIC TESTS AND TESTING

A comment on the "amotivational syndrome" in marijuana smokers, DJ Kupfer, T Detre, J Koral, P Fajans, 1319–1322, Dec 1973
A computer interview for suicide-risk prediction, JH Greist, DH Gustafson, FF Stauss, GL Rowse, TP Laughren, JA Chiles, 1327–1332, Dec 1973
Depersonalization, dysphoria, and thought disturbance, GJ Tucker, M Harrow, D Quinlan, 702–706, June 1973
The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients, LR Marcos, M Alpert, L Urcuyo, M Kesselman, 549–553, May 1973
Factors in the description and grouping of alcoholics, RC Evenson, H Altman, IW Sletten, RR Knowles, and discussion by EM Caffey Jr, 49–54, Jan 1973
Intellectual impairment in uremic patients (Ltrs to Ed), J Yager and NB Levy, and reply of RP Greenberg, G Davis, R Massey, 1159–1161, Oct 1973
Marijuana and amphetamine: the question of interaction, S Zalcman, B Liskow, R Cadoret, D Goodwin, 707–708, June 1973

Opinions about mental illness and political ideology, A Tolor, 1269–1272, Nov 1973
An overview of a psychiatric clinic population, PE Sifneos, 1033–1035, Sept 1973
Parkinsonism, L-dopa, and intelligence, AW Loranger, H Goodell, FH McDowell, JE Lee, RD Sweet, 1386–1389, Dec 1973
Personality characteristics of servicemen returned from Viet Nam identified as heroin abusers, PT Hampton, DB Vogel, 1031–1032, Sept 1973
Phases of psychopathology after assassination, JC Finney, DE Skeeters, CD Auvenshine, DF Smith, 1379–1380, Dec 1973
Psychiatric screening with automated multiphasic health testing in the VA admission procedure, RE Gordon, L Bielen, A Watts, 46–48, Jan 1973
The psychological evaluation of patients for a kidney transplant and hemodialysis program, RP Greenberg, G Davis, R Massey, 274–277, Mar 1973
Testing for mental retardation: comments on standard deviations (Ltr to Ed), RH Ingwell, and reply of J Wortis, 496, April 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973
A study of prediction and outcome in a mental health crisis clinic, LA Gottschalk, RA Fox, DE Bates, 1107–1111, Oct 1973
The volunteer rescue squad: the impact of a group on the psychological adaptation of its members, GW Keating, WA Brown, K Standley, 278–282, Mar 1973

PSYCHOPHYSIOLOGICAL DISORDERS

Duodenal ulcer among Northwest coastal Indian women, JH Shore, DL Stone, 774–777, July 1973
Psychiatric consultations in a children's hospital, EP Monnelly, BM Ianzito, MA Stewart, 789–790, July 1973
Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, LR Loeb, S Peal, FF Loeb Jr, B Templeton, 160–164, Feb 1973
Subjects' recent life changes and coronary heart disease in Finland, RH Rahe, L Bennett, M Romo, P Siltanen, RJ Arthur, 1222–1226, Nov 1973

PSYCHOSURGERY

Lobotomies defended (Ltr to Ed), E Revitch, and reply of PR Breggin, 608–609, May 1973

PSYCHOTHERAPY

Activist and traditionalist approaches in psychiatry (Ltr to Ed), W Reich, and reply of CB Brenneis, D Laub, 825–826, July 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Controversies about the psychotherapy of schizophrenia, JG Gunderson, 677–681, June 1973
Current strains for mental health trainees, CB Brenneis, D Laub, 41–45, Jan 1973
The dream-protein hypothesis, EL Rossi, 1094–1097, Oct 1973
The eclectic approach to the treatment of phobias, KR MacKenzie, and discussion by EM Caffey Jr, 1103–1106, Oct 1973
The effects of regressive ECT with process schizophrenics, LG Murillo, JE Exner Jr, 269–273, Mar 1973
Emotional involvement in psychotherapy (Ltr to Ed), DB Gesenway, and reply of H Spotnitz, 937–939, Aug 1973
The future of psychoanalytic therapy, J Marmor, 1197–1202, Nov 1973
Goal-attainment scaling as a method for evaluating mental health programs, DW Cline, DL Rouzer, D Bransford, 105–108, Jan 1973
Group process research: a factor analytical study, DM Hawkins, CB Norton, C Eisdorfer, D Gianturco, 916–919, Aug 1973
Group psychotherapy supervision and its effect on resident training, WK Grossman, E Karmiol, 920–921, Aug 1973
Implications of the women's liberation movement for psychotherapy, JK Rice, DG Rice, 191–196, Feb 1973
The mystical experience as a suicide preventive, PC Horton, 294–296, Mar 1973
An overview of a psychiatric clinic population, PE Sifneos, 1033–1035, Sept 1973
The polygraph in a psychiatric setting, S Abrams, 94–98, Jan 1973
The practice of hospital psychiatry: a formulation, GJ Tucker, JS Maxmen, 887–891, Aug 1973
A preliminary report on multi-image immediate impact video self-confrontation, MM Berger, 304–306, Mar 1973
Problem formulation: the problem-oriented record, RS Ryback, JS Gardner, 312–316, Mar 1973
The psychotherapy of schizophrenia: an NIMH program, RJ Friedman, JG Gunderson, DB Feinsilver, 674–677, June 1973
The psychotherapy of schizophrenia: does it work? JE Dyrud, PS Holzman, 670–673, June 1973
Shared ethnic scotoma, ET Shapiro, H Pinsker, 1338–1341, Dec 1973
A study of prediction and outcome in a mental health crisis clinic, LA Gottschalk, RA Fox, DE Bates, 1107–1111, Oct 1973
Time-extended group therapy sessions in a remote setting, J Reckless, D Hawkins, A Fauntleroy, 1024–1026, Sept 1973
Treatment of fear of flying, L Solyom, R Shugar, S Bryntwick, C Solyom, and discussion by JM Rhoads, 423–427, April 1973
Truth, honesty, and the therapeutic process, L Salzman, 1280–1282, Nov 1973
Videotape confrontation after attempted suicide, HLP Resnik, WT Davison, D Schuyler, P Christopher, 460–463, April 1973

PYRIDOXINE

Oral contraceptives, pyridoxine, and depression, F Winston, 1217–1221, Nov 1973

RECORD KEEPING

Problem formulation: the problem-oriented record, RS Ryback, JS Gardner, 312–316, Mar 1973
The Weed system and psychiatry (Ltr to Ed), LH Lipsius, 610–611, May 1973

RELIGION

Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
The mystical experience as a suicide preventive, PC Horton, 294–296, Mar 1973
Religious delusions in counter-culture patients, P Levinson, 1265–1269, Nov 1973
Request for writers (Ltr to Ed), CA Frazier, 111, Jan 1973
Therapeutic spiritual experiences (Ltr to Ed), H Farkas, 1045–1046, Sept 1973

RENAL TRANSPLANT

Intellectual impairment in uremic patients (Ltrs to Ed), J Yager and NB Levy, and reply of RP Greenberg, G Davis, R Massey, 1159–1161, Oct 1973
The psychological evaluation of patients for a kidney transplant and hemodialysis program, RP Greenberg, G Davis, R Massey, 274–277, Mar 1973

RISK TAKING

Marijuana and other drug use by women college students: associated risk taking and coping activities, BA Rouse, JA Ewing, and discussion by GS Glass, 486–491, April 1973

RUBIDIUM

Rubidium: biochemical, behavioral, and metabolic studies in humans, RR Fieve, H Meltzer, DL Dunner, M Levitt, J Mendlewicz, A Thomas, 55–61, Jan 1973

SCHIZOPHRENIA

Amphetamine psychosis: a "model" schizophrenia mediated by catecholamines, 61–67, Jan 1973
Antagonistic effects of physostigmine and methylphenidate in man, DS Janowsky, MK El-Yousef, JM Davis, HJ Sekerke, 1370–1376, Dec 1973
Ataractic drugs versus ECT in schizophrenia (Ltr to Ed), J Spensley, and reply of LG Murillo, JE Exner Jr, 1162–1163, Oct 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Confusion about schizophrenia (Ltr to Ed), AS Yusin, 1400, Dec 1973
Controversies about the psychotherapy of schizophrenia, JG Gunderson, 677–681, June 1973
The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
Effects of nutrition on schizophrenia (Ltr to Ed), GA Baker, and reply of FC Dohan, 1400–1401, Dec 1973
The effects of regressive ECT with process schizophrenics, LJ Murillo, JE Exner Jr, 269–273, Mar 1973
Language and thought content in acute psychosis, FE Reilly, M Harrow, GJ Tucker, and discussion by AB Lewis Jr, 411–417, April 1973
The life course of children with schizophrenia, L Bender, 783–786, July 1973
Mesoridazine versus chlorpromazine in acute schizophrenia: a double-blind investigation, TA Hamid, WJ Wertz, 689–692, June 1973
Piperacetazine and chlorpromazine: a comparison, AC Johnson, AS Kulkarni, 603–605, May 1973
The psychotherapy of schizophrenia: an NIMH program, RJ Friedman, JG Gunderson, DB Feinsilver, 674–677, June 1973
The psychotherapy of schizophrenia: does it work? JE Dyrud, PS Holzman, 670–673, June 1973
Relapsed schizophrenics: earlier discharge from the hospital after cereal-free, milk-free diet, FC Dohan, JC Grasberger, 685–688, June 1973
Religious delusions in counter-culture patients, P Levinson, 1265–1269, Nov 1973
Reversal of antiparkinsonian drug toxicity by physostigmine: a controlled study, MK El-Yousef, DS Janowsky, JM Davis, HJ Sekerke, 141–145, Feb 1973
Schizophrenia: a family's projective identification, JR Stabenau, 19–23, Jan 1973
A therapeutic aftercare setting for "refractory" chronic schizophrenic patients, PT Donlon, RT Rada, SW Knight, 682–684, June 1973
The treatment of schizophrenia: illusion or elusion? (Editorial), R Cancro, 693–694, June 1973

SECURITY SCREENING

Psychiatric factors in security screening, L Linn, 648–652, June 1973

SELF-MUTILATION

Self-destructive and suicidal behaviors in a neuropsychiatric inpatient facility, JJ Fabian, MP Maloney, MP Ward, 1383–1385, Dec 1973
Self-enucleation: further views (Ltr to Ed), W Goldsmith, 329, Mar 1973

SEXUAL DEVIANCE

A proposed "dangerous sex offender" law, NT Sidley, FJ Stolarz, 765–768, July 1973

SEXUALITY

Alcohol-induced sexual impotence, F Lemere, JW Smith, 212–213, Feb 1973
Antinuclear factor: age and sex (Ltr to Ed), G Mellsop, S Whittingham, and reply of H von Brauchitsch, 609, May 1973
A brief comment on human sexuality (Ltr to Ed), R Green, 110, Jan 1973
Depression in the menopause, G Winokur, 92–93, Jan 1973
Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
Female patients: intractable or victims of chauvinism? (Ltr to Ed), H Altman, and reply of JH Houck, 495–496, April 1973
Functions of the lower-class partial family, PL Adams, 200–203, Feb 1973
Male transsexualism: uneasiness, RJ Stoller, 536–539, May 1973
Migration and psychopathology of Eskimo women, JD Bloom, 446–449, April 1973
Motivational factors in abortion patients, FJ Kane Jr, PA Lachenbruch, MA Lipton, D Baram, 290–293, Mar 1973
Overview: the impact of new advances in sex research on psychoanalytic theory, RJ Stoller, 241–251, Mar 1973
Physicians and the new sexual freedom, I Siassi, M Thomas, 1256–1257, Nov 1973
Prevalent sexual misconceptions (Ltr to Ed), ML Gerstle, 1403, Dec 1973
Sexual freedom in adolescents: a reaction formation? (Ltr to Ed), WV Hempel, 722, June 1973
A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients, SH Kardener, M Fuller, IN Mensh, 1077–1081, Oct 1973
A symposium: should homosexuality be in the APA nomenclature? RJ Stoller, J Marmor, I Bieber, R Gold, CW Socarides, R Green, RL Spitzer, 1207–1216, Nov 1973

SLEEP STUDIES

The dream-protein hypothesis, EL Rossi, 1094–1097, Oct 1973
Once more: the inaccuracy of non-EEG estimations of sleep, BL Weiss, RJ McPartland, DJ Kupfer, 1282–1285, Nov 1973

SOCIAL ISSUES

About psychiatry, psychiatrists, and social problems (Editorial), VW Bernard, 204–205, Feb 1973
Activist and traditionalist approaches in psychiatry (Ltr to Ed), W Reich, and reply of CB Brenneis, D Laub, 825–826, July 1973
Benjamin Rush: morality in government (Editorial), RE Jones, 1137–1138, Oct 1973
Black liberation, women's liberation, AE Slaby, JR Sealy, 196–200, Feb 1973
Care of the chronically mentally ill—a national disgrace (Editorial), R Reich, 911–912, Aug 1973
Cheap labor from poor nations, EF Torrey, RL Taylor, and discussion by R Cserr, 428–434, April 1973
The crisis of financing residency training in psychiatry: a diagnosis (Ltr to Ed), RS Daniels, 496–497, April 1973
The death of Lyndon B. Johnson (Ltr to Ed), AS Schubert, 611, May 1973
"Diagnosing" political candidates (Ltr to Ed), VM Cox Jr, 109–110, Jan 1973
Dumping of patients: funding and statistics a problem (Ltr to Ed), HM Kase, 111, Jan 1973
"Dying with their rights on" (Ltr to Ed), DA Treffert, 1041, Sept 1973

Emergency psychiatric hospitalization via court order: a critique, J Zusman, S Shaffer, 1323–1326, Dec 1973
Empty hospital beds and human misery (Ltrs to Ed), ZM Lebensohn and JE Blank, 1401–1402, Dec 1973
Female patients: intractable or victims of chauvinism? (Ltr to Ed), H Altman, and reply of JH Houck, 495–496, April 1973
Foreign medical graduates: a symposium, MH Miller, F Workneh, EB Brody, DJ Lewis, T-y Lin, and discussion by L Ganser, B Holland, J Smith e Incas, W Shervington, JS Steinberg, CH Fellner, 435–441, April 1973
The funding crisis: an opportunity for growth (Ltr to Ed), JM Scanlan, T Rodgers, IM Hilliard, WB Carter, TH Billingsley, T Foster, AA Axelson, 823, July 1973
Implications of the women's liberation movement for psychotherapy, JK Rice, DG Rice, 191–196, Feb 1973
Is psychiatry as establishment an effective force? MH Miller, J Auerbach, 761–764, July 1973
Lobotomies defended (Ltr to Ed), E Revitch, and reply of PR Breggin, 608–609, May 1973
Making abortion consultation therapeutic, CM Friedman, 1257–1261, Nov 1973
Marriage, family, and parenthood, H Greenbaum, 1262–1265, Nov 1973
Medicine: a career conflict for women, MT Notman, CC Nadelson, and discussion by CB Wilbur, 1123–1127, Oct 1973
Mental health of political candidates: notes on Abraham Lincoln (Ltr to Ed), RW Hudgens, 110, Jan 1973
The nonpsychotic organic brain syndrome, B Feldshuh, J Sillen, B Parker, W Frosch, 1026–1029, Sept 1973
The Presidential Address: a time for action, PC Talkington, 745–747, July 1973
The psychiatrist and family planning (Editorial), EB Brody, 1273–1274, Nov 1973
Quaalude alley: a one-way street, TP Bridge, EH Ellinwood Jr, 217–219, Feb 1973
Response to the Presidential Address, AM Freedman, 748–749, July 1973
The responsibilities of psychiatry to medicine: a debate (Ltrs to Ed), JC Beck, M Braun, NQ Brill, JS Eaton Jr, KE Godfrey, KH Gruberg, JA Kindwall, B Kuhner, B Liptzin, RT London, JL Mathis, AE Penetrante, AR Sorvino, HM Voth, and A Werner, and reply of GL Engel, 223–227, Feb 1973
The road to Shangri-La is paved with vitamins, R Bitensky, 1253–1256, Nov 1973
The role of psychiatry in war and poverty (Ltr to Ed), V Bernard, J Bullette, R Gorney, L Grinspoon, J Handler, J Marmor, R Menninger, P Ottenberg, K Smith, R Wilkerson, 109, Jan 1973
Statements about Viet Nam: APA's role (Ltrs to Ed), H Corral and WC Johnson, 721–722, June 1973
Suicide and the right to die (Editorial), GE Murphy, 472–473, April 1973
Therapeutic abortion and a prior psychiatric history, JA Ewing, BA Rouse, 37–40, Jan 1973
Training the woman resident to be a psychiatrist, EP Benedek, 1131–1135, Oct 1973
True and false experts: a second look, DS Werman, 1351–1354, Dec 1973
Viet Nam: the Board of Trustees steps out of bounds (Ltr to Ed), EJ Gunderson, 610, May 1973
Women in psychiatry (Editorial), RZ Solomon, 1136–1137, Oct 1973
Women in psychiatry: past and present areas of concern, NA Roeske, 1127–1131, Oct 1973
Women psychiatrists in the United States, M Scher, 1118–1122, Oct 1973

SOCIAL PREJUDICE

Black liberation, women's liberation, AE Slaby, JR Sealy, 196–200, Feb 1973
The effects of social prejudice on hospitalized adolescents, PG Rossman, D Miller, 1029–1031, Sept 1973
Functions of the lower-class partial family, PL Adams, 200–203, Feb 1973
Social psychiatric impairment: racial comparisons, JJ Schwab, NH McGinnis, GJ Warheit, 183–187, Feb 1973

SOCIAL PSYCHIATRY

Aggression and social synergy (Editorial), CD Aring, 297–298, Mar 1973
Changing human service delivery systems: their influences on psychiatric training, RS Daniels, 1232–1236, Nov 1973
Changing styles in psychiatric syndromes: a symposium, JL Schimel, L Salzman, P Chodoff, RR Grinker Sr, OA Will Jr, 146–155, Feb 1973
Chronic marijuana use and psychosocial adaptation, JS Hochman, NQ Brill, and discussion by TC Rodgers, 132–140, Feb 1973
Community mental health services in Britain, D Bennett, 1065–1070, Oct 1973
The concept of child advocacy, JF McDermott Jr, WM Bolman, AM Arensdorf, RA Markoff, 1203–1206, Nov 1973
Coping with problems: attitudes toward children who set fires, CN Winget, RN Whitman, 442–445, April 1973
Crisis, conversion, and cult formation: an examination of a common psychosocial sequence, HM Adler, VBO Hammett, 861–864, Aug 1973
Current strains for mental health trainees, CB Brenneis, D Laub, 41–45, Jan 1973
Drug abuse, sexual attitudes, political radicalization, and religious practices of college seniors and public school teachers, S Janus, B Bess, 187–191, Feb 1973
The effect of financing on psychiatric care, RW Gibson, 299–301, Mar 1973
The effect of interview language on the evaluation of psychopathology in Spanish-American patients, LR Marcos, M Alpert, L Urcuyo, M Kesselman, 549–553, May 1973
The effects of social prejudice on hospitalized adolescents, PG Rossman, D Miller, 1029–1031, Sept 1973
Epidemiological differences between white and nonwhite suicide attempters, AM Pederson, GA Awad, AR Kindler, 1071–1076, Oct 1973
The Euclid House: a therapeutic halfway house for prisoners, SL Aledort, M Jones, 286–289, Mar 1973
"The fitness factory," part I: the psychiatrist's role in determining competency, RL Goldstein, 1144–1147, Oct 1973
Functions of the lower-class partial family, PL Adams, 200–203, Feb 1973
The future of psychiatric education, LJ West, 521–528, May 1973
Illnesses of the spirit among the Serer of Senegal, M Beiser, WA Burr, J-L Ravel, H Collomb, 881–886, Aug 1973
Indian education: a human systems analysis, CA Hammerschlag, CP Alderfer, D Berg, 1098–1102, Oct 1973
Landlord-supervised cooperative apartments: a new modality for community-based treatment, C-p Chien, JO Cole, 156–159, Feb 1973
Migration and psychopathology of Eskimo women, JD Bloom, 446–449, April 1973
Modern man and his instinct of workmanship, JM Kreps, 179–183, Feb 1973
Motivation for medicine in the seventies, JF McDermott Jr, WF Char, MJ Hansen, 252–256, Mar 1973
Opinions about mental illness and political ideology, A Tolor, 1269–1272, Nov 1973
Overview: current trends in mental health law, AL McGarry, HA Kaplan, 621–630, June 1973
An overview of crisis intervention in the emergency rooms of general hospitals, G Bartolucci, CS Drayer, 953–960, Sept 1973
Peer review: prospects and problems, DG Langsley, 301–304, Mar 1973
Political psychiatry: the psychiatrist in elective public office, E Messner, 283–285, Mar 1973
Popular attitudes and beliefs about tranquilizers, DI Manheimer, ST Davidson, MB Balter, GD Mellinger, IH Cisin, HJ Parry, 1246–1253, Nov 1973
The private practice of community psychiatry, WT Vaughan Jr, DE Newman, A Levy, S Marty, 24–27, Jan 1973

Problems associated with the introduction of a psychiatric unit into a rural general hospital, S Bloomberg, 28–31, Jan 1973
Psychiatric assessment of 30 chronic users of cannabis and 30 matched controls, MH Beaubrun, F Knight, 309–311, Mar 1973
Psychiatric residents: a survey of training needs, satisfactions, and social attitudes, FE Fried, EG Doherty, L Coyne, 1342–1345, Dec 1973
Psychiatrists in the ghetto (Ltr to Ed), PA Roemer, and reply of WM Bolman, 720, June 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973
Psychiatry in the functionally organized undergraduate curriculum, RE Becker, RM Wintrob, R Cancro, JR Stabenau, 571–574, May 1973
Psychiatry in the United States and the USSR: a comparison, MG Allen, 1333–1337, Dec 1973
Religious delusions in counter-culture patients, P Levinson, 1265–1269, Nov 1973
Resentment and suspicion among American men, MD Blumenthal, 876–880, Aug 1973
Shared ethnic scotoma, ET Shapiro, H Pinsker, 1338–1341, Dec 1973
Social psychiatric impairment: racial comparisons, JJ Schwab, NH McGinnis, GJ Warheit, 183–187, Feb 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
Social systems and the criteria of health as defined by the World Health Organization, A Jus, 125–131, Feb 1973
Speaking out on Jewish young people (Ltrs to Ed), N Simon and R Seidenberg, and reply of M Ostow, 607–608, May 1973
Suicidal behavior in Edinburgh and Seattle, HS Ripley, 995–1001, Sept 1973
The therapeutic utilization of the juvenile court, Y Nir, R Cutler, 1112–1117, Oct 1973
Western humanism, modern liberal politics, and psychiatric training: friends or foes? AJ Mandell, 529–531, May 1973

SUCCINYLCHOLINE

Drug dosage in ECT (Ltrs to Ed), M Simonson, DF Wehlage, PH Blachly, and DJ Impastato, and reply of CH Thigpen, 1293–1294, Nov 1973
Succinylcholine in EST (Ltr to Ed), CH Thigpen, 722, June 1973

SUICIDE

Basic research and suicide prevention (Ltr to Ed), D Lester, 1402–1403, Dec 1973
A computer interview for suicide-risk prediction, JH Greist, DH Gustafson, FF Stauss, GL Rowse, TP Laughren, JA Chiles, 1327–1332, Dec 1973
Epidemiological differences between white and nonwhite suicide attempters, AM Pederson, GA Awad, AR Kindler, 1071–1076, Oct 1973
Hopelessness, depression, and attempted suicide, K Minkoff, E Bergman, AT Beck, R Beck, 455–459, April 1973
The mystical experience as a suicide preventive, PC Horton, 294–296, Mar 1973
No-suicide decisions: a procedural rule (Ltr to Ed), R Grumet, and reply of RC Drye, 1163, Oct 1973
No-suicide decisions: patient monitoring of suicidal risk, RC Drye, RL Goulding, ME Goulding, 171–174, Feb 1973
Self-destructive and suicidal behaviors in a neuropsychiatric inpatient facility, JJ Fabian, MP Maloney, MP Ward, 1383–1385, Dec 1973
Suicidal behavior in Edinburgh and Seattle, HS Ripley, 995–1001, Sept 1973
Suicide and newspapers: a replicated study, S Blumenthal, L Bergner, 468–471, April 1973
Suicide and psychiatric education, WA Kelly Jr, 463–468, April 1973
Suicide and the psychiatrist (Ltr to Ed), M Ross, 937, Aug 1973
Suicide and the right to die (Editorial), GE Murphy, 472–473, April 1973
Symptomatology of depressive illness in Afghanistan, R Waziri, 213–217, Feb 1973
Videotape confrontation after attempted suicide, HLP Resnik, WT Davison, D Schuyler, P Christopher, 460–463, April 1973

SYMPTOMATOLOGY

The one-week prevalence of symptoms in neurotic patients and normals, R Kellner, BF Sheffield, 102–105, Jan 1973
Symptomatology of depressive illness in Afghanistan, R Waziri, 213–217, Feb 1973

SYSTEMATIC DESENSITIZATION

The current status of systematic desensitization, J Wolpe, JP Brady, M Serber, WS Agras, RP Liberman, 961–965, Sept 1973
The eclectic approach to the treatment of phobias, KR MacKenzie, and discussion by EM Caffey Jr, 1103–1106, Oct 1973

SYSTEMS ANALYSIS

Indian education: a human systems analysis, CA Hammerschlag, CP Alderfer, D Berg, 1098–1102, Oct 1973
Problem formulation: the problem-oriented record, RS Ryback, JS Gardner, 312–316, Mar 1973

TARDIVE DYSKINESIA

Is tardive dyskinesia a drug effect? (Ltr to Ed), GE Crane, and reply of JP Curran, 1043–1044, Sept 1973
Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, H Kazamatsuri, C-p Chien, JO Cole, 479–483, April 1973
Management of tardive dyskinesia with thiopropazate, JP Curran, 925–927, Aug 1973
Methylphenidate in tardive dyskinesia, WE Fann, JM Davis, IC Wilson, 922–924, Aug 1973
The pharmacology of tardive dyskinesias, HL Klawans Jr, 82–86, Jan 1973
Rapid reversal of tardive dyskinesia (Ltr to Ed), GE Crane, 1159, Oct 1973
Tardive dyskinesia and low dosage (Ltr to Ed), WE Thornton, BP Thornton, 1401, Dec 1973
Tardive dyskinesia: side effect or not? JP Curran, 406–410, April 1973
Treatment for tardive dyskinesia (Ltr to Ed), JA Winn, 496, April 1973

TELEVISION

Telepsychiatry: psychiatric consultation by interactive television, TF Dwyer, 865–869, Aug 1973

TETRABENAZINE

Long-term treatment of tardive dyskinesia with haloperidol and tetrabenazine, H Kazamatsuri, C-p Chien, JO Cole, 479–483, April 1973

THIAMINE HYDROCHLORIDE

Prevention of alcohol withdrawal seizures: the roles of diphenylhydantoin and chlordiazepoxide, E Rothstein, 1381–1382, Dec 1973

THIOPROPAZATE

Management of tardive dyskinesia with thiopropazate, JP Curran, 925–927, Aug 1973

THIOTHIXENE

Antagonism of guanethidine by chlorpromazine, DS Janowsky, MK El-Yousef, JM Davis, WE Fann, 808–812, July 1973

TRANSACTIONAL ANALYSIS

No-suicide decisions: a procedural rule (Ltr to Ed), R Grumet, and reply of RC Drye, 1163, Oct 1973
No-suicide decisions: patient monitoring of suicidal risk, RC Drye, RL Goulding, ME Goulding, 171–174, Feb 1973

TRANSCULTURAL PSYCHIATRY

Acupunctural analgesia: its explanation by conditioning theory, autogenic training, and hypnosis, WS Kroger, 855–860, Aug 1973
Cheap labor from poor nations, EF Torrey, RL Taylor, and discussion by R Cserr, 428–434, April 1973
Community mental health services in Britain, D Bennett, 1065–1070, Oct 1973
Duodenal ulcer among Northwest coastal Indian women, JH Shore, DL Stone, 774–777, July 1973
The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients, LR Marcos, M Alpert, L Urcuyo, M Kesselman, 549–553, May 1973
Illnesses of the spirit among the Serer of Senegal, M Beiser, WA Burr, J-L Ravel, H Collomb, 881–886, Aug 1973
Indian education: a human systems analysis, CA Hammerschlag, CP Alderfer, D Berg, 1098–1102, Oct 1973
Indian peyotists and alcohol (Ltr to Ed), C Roy, 329–330, Mar 1973
Migration and psychopathology of Eskimo women, JD Bloom, 446–449, April 1973
The one-week prevalence of symptoms in neurotic patients and normals, R Kellner, BF Sheffield, 102–105, Jan 1973
Psychiatric assessment of 30 chronic users of cannabis and 30 matched controls, MH Beaubrun, F Knight, 309–311, Mar 1973
Psychiatry in Shanghai, China: observations in 1973, DN Ratnavale, 1082–1087, Oct 1973
Psychiatry in South Korea, SC Chang, K-i Kim, 667–669, June 1973
Psychiatry in the United States and the USSR: a comparison, MG Allen, 1333–1337, Dec 1973
Psychiatry with the aborigines of West Malaysia, JD Kinzie, JM Bolton, 769–773, July 1973
A school for medicine men, RL Bergman, 663–666, June 1973
Social psychiatry: an overview, RJ Arthur, 841–849, Aug 1973
Social systems and the criteria of health as defined by the World Health Organization, A Jus, 125–131, Feb 1973
Some aspects of the history of Swiss psychiatry, M Bleuler, 991–994, Sept 1973
Subjects' recent life changes and coronary heart disease in Finland, RH Rahe, L Bennett, M Romo, P Siltanen, RJ Arthur, 1222–1226, Nov 1973
Suicidal behavior in Edinburgh and Seattle, HS Ripley, 995–1001, Sept 1973
Symptomatology of depressive illness in Afghanistan, R Waziri, 213–217, Feb 1973

TRANSSEXUALISM

Male transsexualism: uneasiness, RJ Stoller, 536–539, May 1973

TRIMIPRAMINE

Single versus divided daily dose of trimipramine in the treatment of depressive illness, MZ Hussain, ZA Chaudhry, 1142–1144, Oct 1973

TWIN STUDIES

The dimethyltryptamine-forming enzyme in blood platelets: a study in monozygotic twins discordant for schizophrenia, RJ Wyatt, JM Saavedra, R Belmaker, S Cohen, W Pollin, 1359–1361, Dec 1973
Schizophrenia: a family's projective identification, JR Stabenau, 19–23, Jan 1973
Screen memories in a pair of monozygotic twins discordant for involutional depression and psychophysiological disorders, LR Loeb, S Peal, FF Loeb Jr, B Templeton, 160–164, Feb 1973

VIDEOTAPE

The effect of interview language on the evaluation of psychopathology in Spanish-American schizophrenic patients, LR Marcos, M Alpert, L Urcuyo, M Kesselman, 549–553, May 1973
Evaluation of the SAID teaching program, DW Cline, JN Garrard, 582–585, May 1973
A medical interviewing course: objectives, techniques, and assessment, DW Cline, JN Garrard, 574–578, May 1973
A preliminary report on multi-image immediate impact video self-confrontation, MM Berger, 304–306, Mar 1973
Teaching communication skills in medical school, J Waldron, 579–581, May 1973
A test of clinical learning by medical students, RJ Thurnblad, H Muslin, J Loesch, 568–570, May 1973
Video feedback in treating hyperkinetic children: a preliminary report, S Furman, A Feighner, 792–796, July 1973
Videotape confrontation after attempted suicide, HLP Resnik, WT Davison, D Schuyler, P Christopher, 460–463, April 1973

VITAMINS

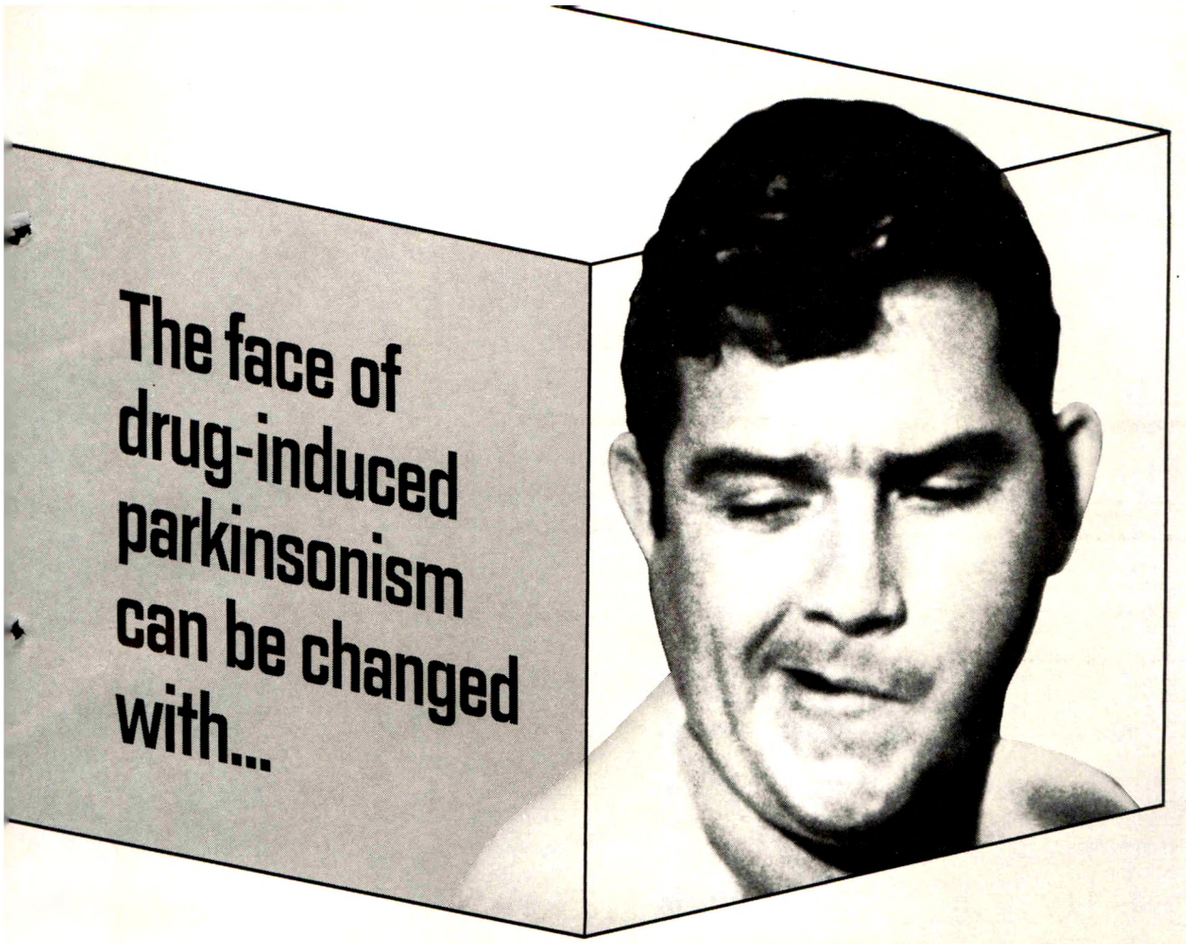
The road to Shangri-La is paved with vitamins, R Bitensky, 1253–1256, Nov 1973

WATER INTOXICATION

Compulsive water drinking (Ltr to Ed), WK Thomsen, B Prince, T Kilgore, 610, May 1973

WOMEN AND PSYCHIATRY

Black liberation, women's liberation, AE Slaby, JR Sealy, 196–200, Feb 1973
Implications of the women's liberation movement for psychotherapy, JK Rice, DG Rice, 191–196, Feb 1973
Marriage, family, and parenthood, H Greenbaum, 1262–1265, Nov 1973
Medicine: a career conflict for women, MT Notman, CC Nadelson, and discussion by CB Wilbur, 1123–1127, Oct 1973
Training the woman resident to be a psychiatrist, EP Benedek, 1131–1135, Oct 1973
Women in psychiatry (Editorial), RZ Solomon, 1136–1137, Oct 1973
Women in psychiatry: past and present areas of concern, NA Roeske, 1127–1131, Oct 1973
Women psychiatrists in the United States, M Scher, 1118–1122, Oct 1973

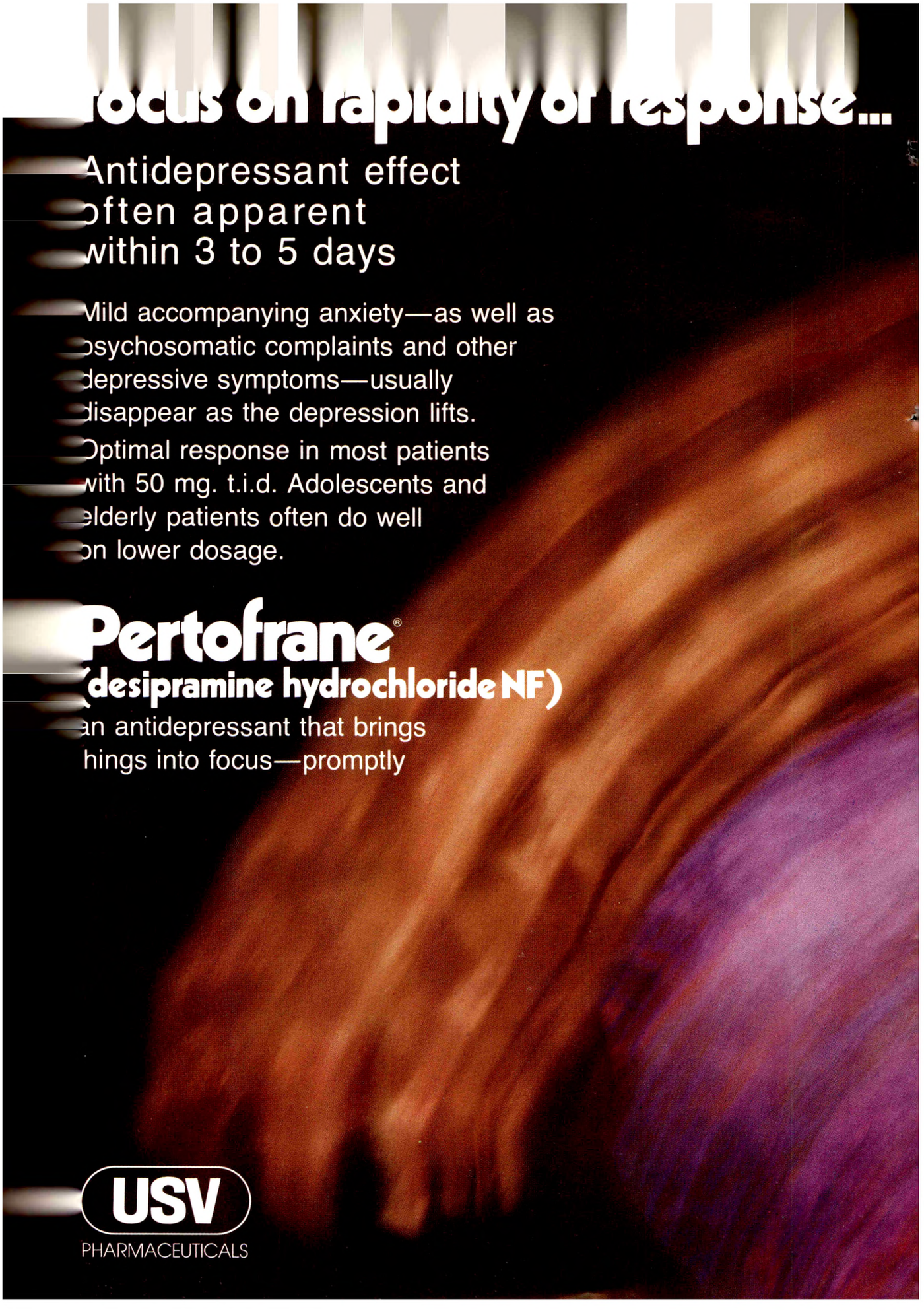


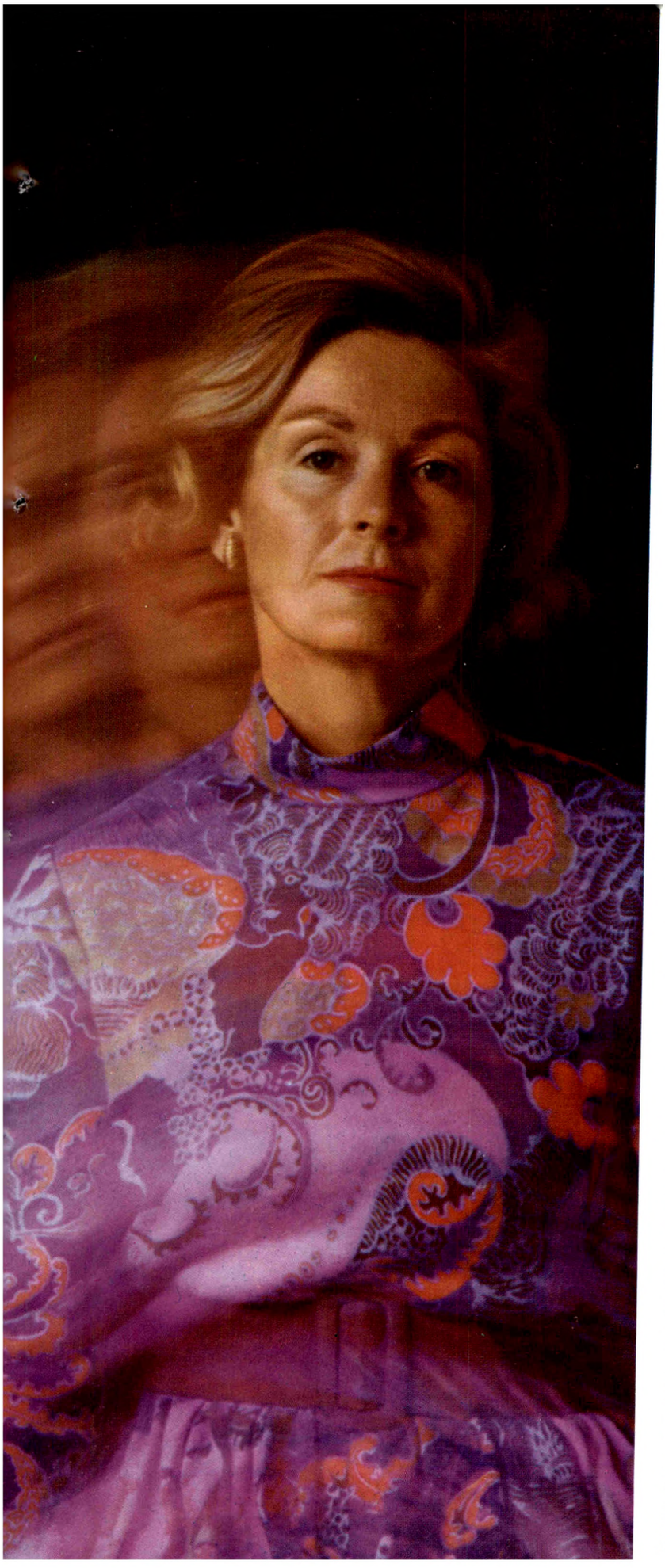
AKINETON®
(biperiden)

- relieves extrapyramidal reactions
- reduces akinesia and rigidity
- combines well with other anti-parkinson agents
- more than ten years of clinical experience

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS: Isolated instances of mental confusion, euphoria, agitation and disturbed behavior have been reported in susceptible patients. Use with caution in manifest glaucoma, prostatism and cardiac arrhythmia. Dry mouth, blurred vision and drowsiness appear infrequently. Some decrease in urinary flow has been noted in a few patients. If gastric irritation occurs, it may be avoided by administering during or after meals. With parenteral administration, mild transient postural hypotension may be evidenced. The only known contraindication is sensitivity to Akineton (biperiden.) DOSAGE: Orally: **Parkinsonism:** 1 tablet, 2 mg., 3 or 4 times daily. **Drug-induced extrapyramidal disorders:** 1 tablet, 2 mg., 1 to 3 times daily. Parenterally: the average adult dose is 2 mg. intramuscularly or intravenously. May be repeated every half-hour until resolution of symptoms is effected, but not more than 4 consecutive doses should be administered in a 24-hour period. SUPPLIED: Tablets—2 mg. (bisected) Akineton HCl. Ampules—1 ml. containing 5 mg. Akineton lactate in an aqueous 1.4% sodium lactate solution.

KNOLL PHARMACEUTICAL COMPANY · WHIPPANY, NEW JERSEY 07981 · TORONTO, CANADA


Focus on rapidity of response...
Antidepressant effect often apparent within 3 to 5 days
Mild accompanying anxiety—as well as psychosomatic complaints and other depressive symptoms—usually disappear as the depression lifts.
Optimal response in most patients with 50 mg. t.i.d. Adolescents and elderly patients often do well on lower dosage.
Pertofrane®
(desipramine hydrochloride NF)
an antidepressant that brings things into focus—promptly
USV
PHARMACEUTICALS



Pertofrane®
(desipramine hydrochloride)

Indication: For relief of mental depression.
Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal. When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed. The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants. **Warnings:** Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm. Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold). This drug may block the action of the antihypertensive, guanethidine, and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery. The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures. Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery. Do not use in women who are or may become pregnant, or in children under 12 years of age, unless the clinical situation warrants the potential risk. Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients. **Precautions:** Potentially suicidal patients require careful supervision and protective measures during therapy. Prescriptions should be limited to small quantities. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances. Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy. **Adverse Reactions:** The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.
Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily. Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response. Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated. **How Supplied:** 25 mg. capsules (pink) and 50 mg. capsules (maroon and pink), bottles of 100 and 1000; single-dose blister packs, boxes of 500.

USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707

Today, she managed a smile



(Not long ago, she couldn't stop sobbing)

Before he sees that first positive response—however hesitant and tentative—the physician may have to bring into play many different aspects of therapy. Establishing a therapeutic relationship may be the first difficulty as well as the first necessity. Psychotherapy, family and community support, occupational and social counseling, and drug therapy may all have to be enlisted.

The characteristically rapid energizing action of VIVACTIL may help establish early therapeutic rapport by lessening the patient's lethargy—often during the first week of medication. VIVACTIL helps elevate mood, usually within the third or fourth week of treatment.

Characteristically, the drug has no sedating or tranquilizing properties. (Symptoms such as anxiety or agitation may be aggravated.)

Dosage of VIVACTIL must be individualized, and patients should be under close medical supervision. For many adult patients with clinically significant depression, 10 mg t.i.d. may provide control of symptoms. Others may require as little as 15 mg or as much as 60 mg a day. In elderly patients and adolescents, lower dosages are recommended.

In depression,

TABLETS, 5 mg and 10 mg

Vivactil®

(Protriptyline HCl | MSD) helps establish early therapeutic rapport

Contraindications: Known hypersensitivity; acute recovery phase following myocardial infarction. Should not be given concomitantly with an MAOI; hyperpyretic crises, severe convulsions, and deaths have occurred in patients receiving tricyclic antidepressant and MAOI drugs simultaneously. When it is desired to substitute protriptyline HCl for an MAOI, a minimum of 14 days should be allowed to elapse after the latter is discontinued. Protriptyline HCl should then be initiated cautiously with gradual increase in dosage until optimum response is achieved.

Warnings: May block the antihypertensive effect of guanethidine or similarly acting compounds. May impair mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Should be used with caution in patients with a history of seizures and, because of its autonomic activity, in patients with a tendency to urinary retention or increased intraocular tension.

Tachycardia and postural hypotension may occur more frequently than with other antidepressant drugs. Should be used with caution in elderly patients and patients with cardiovascular disorders; such patients should be observed closely because of the tendency of the drug to produce tachycardia, hypotension, arrhythmias, and prolongation of the conduction time. Myocardial infarction and stroke have occurred with drugs of this class. On rare occasions, hyperthyroid patients or those receiving thyroid medication may develop arrhythmias when this drug is given.

Usage in Children: Not recommended for use in children because safety and effectiveness in the pediatric age group have not been established.

Usage in Pregnancy: Safe use in pregnancy and lactation has not been established; therefore, use in pregnant women, nursing mothers, or women who may become pregnant requires that possible benefits be weighed against possible hazards to mother and child.

Precautions: When protriptyline HCl is used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; likewise, in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase; paranoid delusions, with or without associated hostility, may be exaggerated. In any of these circumstances, it may be advisable to reduce the dose of protriptyline HCl or to use a major tranquilizing drug concurrently. Symptoms, such as anxiety or agitation, may be aggravated in overactive or agitated patients.

When given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. May enhance response to alcohol and effects of barbiturates and other CNS depressants. Possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent administration with electroshock therapy may increase hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue drug several days before elective surgery, if possible. Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension.

Cardiovascular: hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Overdosage: The intravenous administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning in humans. Animal studies have shown that physostigmine also reverses certain toxic effects of protriptyline, but to a lesser extent.

How Supplied: Tablets, containing 5 mg and 10 mg protriptyline HCl each, in single-unit packages of 100 and bottles of 100 and 1000.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

addendum

MSD
MERCK SHARP & DOHME

MSD 79 5 mg (orange)

MSD 47 10 mg (yellow)

The usual regimen for adults is 15 to 40 mg a day divided into three or four doses. Dosage may be increased to 60 mg a day if necessary.

In elderly and adolescent patients, lower dosages are recommended; initially, a regimen of 5 mg t.i.d. is suggested with adjustment as necessary to the required amount. In elderly patients, the cardiovascular system must be monitored closely when the daily dose exceeds 20 mg.

Because VIVACTIL (Protriptyline HCl, MSD) characteristically is a nonsedating tricyclic antidepressant, activating and energizing in effect, the last dose of the day should be given no later than mid-afternoon to avoid insomnia. Required increases should be added to the morning dose.

When necessary to increase dosage, it should be done gradually. After satisfactory improvement has been achieved, dosage should be reduced to the smallest amount that will maintain relief of symptoms. Maintenance therapy should be continued for at least three months after satisfactory improvement occurs.

(*Usage in Children:* In view of the lack of experience in children, this drug is not recommended for patients under 12 years of age.)

R.S.V.P.



She just doesn't respond to things. No interest. No energy. Discouraged.

It may be mild depression. She needs help...and she needs it now.

Counsel and reassurance may suffice. But if you decide supportive medication is indicated, Ritalin can offer prompt benefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough... to help provide an answer to mild depression.

Ritalin®
(methylphenidate)
helps the patient respond in mild depression*

Ritalin® hydrochloride©
(methylphenidate hydrochloride)

TABLETS

INDICATION
Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: Mild depression
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS
Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS
Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established.
Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available.
Although a causal relationship has not been established, suppression of growth (*ie*, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.
Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states.
Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.
Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.
Drug Interactions
Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.
Usage in Pregnancy
Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence
Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS
Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS
Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported.
Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss.
In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

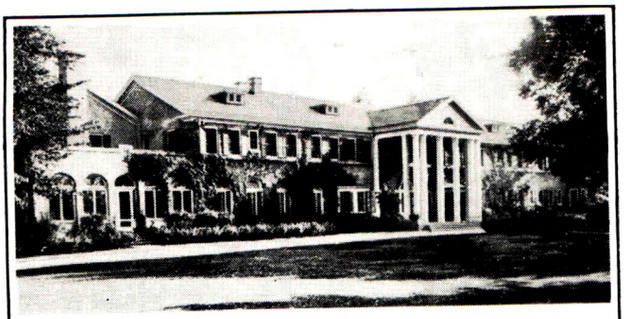
DOSAGE AND ADMINISTRATION
Adults
Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response.
Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. The few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED
Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901 2/4783-1 17

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

CIBA



Milwaukee Psychiatric Hospital — Intensive, dynamic psychotherapy for adults and adolescents, individually-planned activity therapy.

Adolescent Therapy Unit — Designed for the problems of today's emotionally disturbed youth. Patients attend accredited Kradwell High School on the grounds . . . excellent teaching staff . . . credits are transferrable.

Dewey Center — Acute detoxification and inpatient treatment for persons with dependency on alcohol and other drugs, daily schedules, broad supportive services.

Milwaukee Sanitarium — Custodial services for persons with chronic emotional and geriatric illnesses.

Affiliated with the Medical College of Wisconsin
Accredited by the Joint Commission on Accreditation of Hospitals
Non-Sectarian • Non-Profit

Units of MILWAUKEE SANITARIUM FOUNDATION

For information contact Executive Director
1220 Dewey Avenue • Wauwatosa, Wis. 53213 • (414) 258-2600

Participating Member Blue Cross-Blue Shield • approved for participation under Medicare

FAIR OAKS HOSPITAL
and
ADOLESCENT UNIT

Summit, N. J. 07901 **(201) 277-0143**

An intensive treatment mental health center with State and Joint Commission Accreditation for ages commencing with adolescence and continuing through the Medicare years.

SERGIO D. ESTRADA, M.D., Medical Director

OSCAR ROZETT, M.D., Medical Administrator

GRANVILLE L. JONES, M.D., Director of Research

DONALD H. GENT, M.D., Chief, Adolescent Program

MISS M. M. KENNEDY, R.N., B.S., Director, Nursing Service

Electro shock therapy. Indoklon shock therapy. Insulin coma therapy. Pharmaco therapy. Individual and Group psychotherapy. Complete Occupational, Recreational and Social Service Departments.

For descriptive literature write
THOMAS P. PROUT, JR., Administrator

BALDPATE, INC.

A PRIVATE PSYCHIATRIC HOSPITAL
GEORGETOWN, MASS. 01830
(617) 352-2131

Located 30 miles north of Boston on 130 acres, set among peaceful meadows bordering a quiet lake and wooded hill, Baldpate presents a relaxing atmosphere to the problem-beset patient.

Baldpate is an active treatment hospital for psychoses, neuroses, alcoholism, and drug addiction.

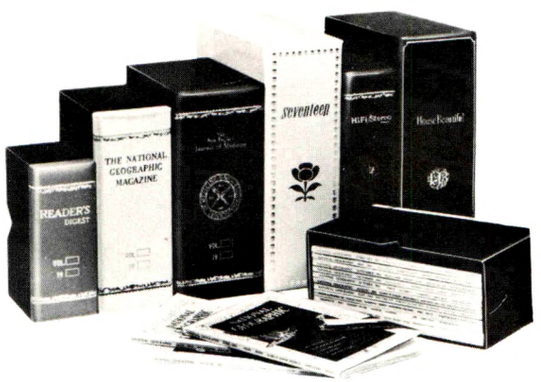
Psychotherapy, somatic therapy, milieu therapy, and pharmacotherapy are available from qualified physicians. There is also occupational and recreational therapy under the direction of trained therapists.

Single rooms with and without bath, shared accommodations, and cottages are available.
Most major health insurance plans acceptable.

PATRICK J. QUIRKE, M.D.
Medical Director

IBRAHIM BAHRAWY, M.D.
Clinical Director

For descriptive literature write:
JAMES K. MCKINIRY, Administrator



THE AMERICAN JOURNAL OF PSYCHIATRY

NOW, your journals can become an attractive permanent part of your professional library. These famous Jesse Jones volume files, especially designed to keep your copies orderly, readily accessible for future reference—guard against soiling, tearing, wear or misplacement of copies. These durable files will support 150 lbs. Looks and feels like leather and is washable. The 23-carat gold lettering makes it a fit companion for the most costly binding.

Reasonably priced, too. Only $4.25, 3 for $12.00, 6 for $22.00 POSTPAID U. S. A. ORDERS ONLY. Satisfaction unconditionally guaranteed or your money back.

JESSE JONES BOX CORP. (Since 1843)
Department JP9—Philadelphia 41, Pa. 19141

THE ONLY TRICYCLIC ANTIDEPRESSANT AVAILABLE IN A 100-MG. CAPSULE



NEW SINEQUAN® 100 MG. CAPSULES
DOXEPIN HCl

May be of particular value in clinical depression/anxiety with accompanying sleep disturbances.

BRIEF SUMMARY
Sinequan® (doxepin HCl) **Capsules**
Contraindications. Sinequan is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan, however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

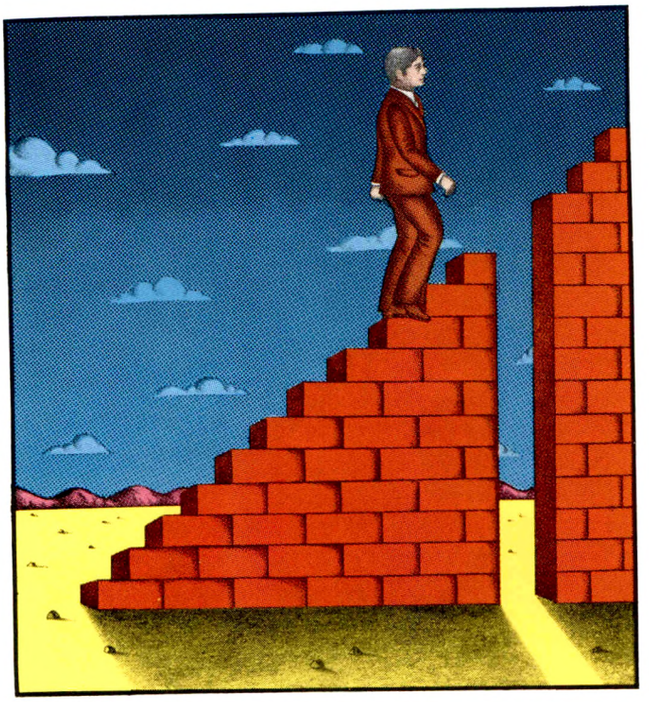
Supply. Sinequan is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., 50 mg., and 100 mg. of doxepin in bottles of 100, 1000, and unit-dose packages of 100 (10 x 10's).

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
PFIZER INC

The psychoneurotic patient's prognosis may be good...

As a group, psychoneurotic patients tend to respond positively to psychotherapy. Follow-up studies indicate that up to two-thirds of treated patients may show significant and often sustained improvement.



In individual cases, the prognosis appears particularly favorable for the psychoneurotic who has had a good premorbid personality structure and a record of reasonably good interpersonal competence. As might be expected, patients judged to be "attractive" candidates for therapy often tend to derive greater benefits from therapeutic intervention than those considered "unattractive."

The global assessment of "attractiveness" is influenced by such factors as youthfulness, intelligence, ability to relate and good occupational history.

But excessive anxiety can block recovery...

Anxiety is the hallmark of psychoneurotic states. In excess it may not alter the patient's "prognostic rating," but it can slow therapeutic progress—sometimes to a marked extent. At the outset of therapy, for instance, severe or persistent anxiety can be particularly

obstructive, sometimes hampering for long periods the patient's ability to participate in a productive psychotherapeutic relationship. At later stages, intense anxiety may impair the patient's receptivity to further probing and block his attempts to retrieve and express pertinent material.

When the patient's disabling anxiety continues to impede therapeutic progress, management of his condition may often be significantly facilitated by adjunctive Librium (chlordiazepoxide HCl).

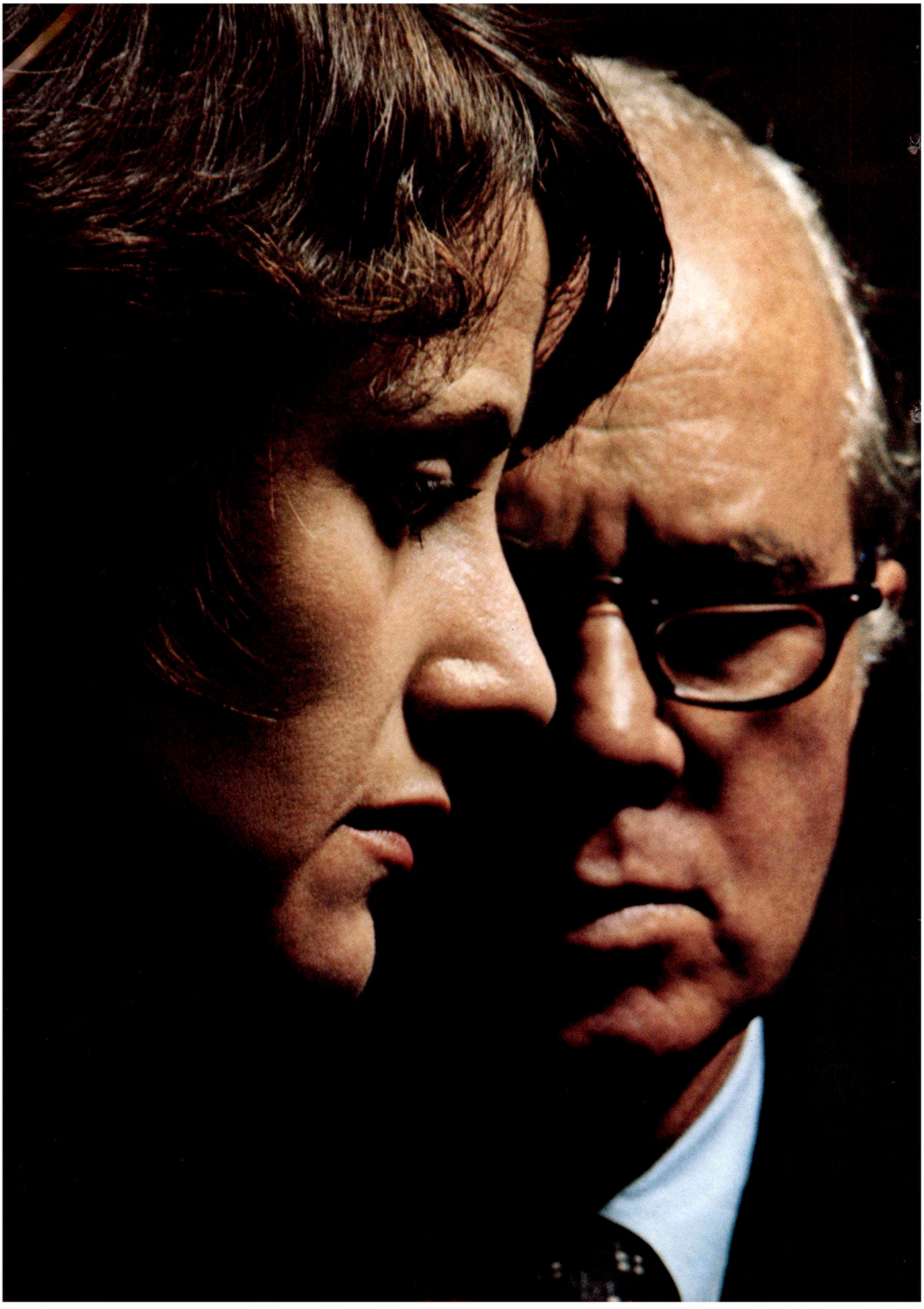
Librium generally relieves excessive anxiety without unduly impairing mental acuity or ability to perform. As with all CNS-acting drugs, however, patients should be cautioned against hazardous occupations requiring complete mental alertness. (See Warnings section in summary of prescribing information.) When the patient's anxiety has been reduced to appropriate levels, Librium should, of course, be discontinued.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

To relieve obstructive anxiety consider Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules
Up to 100 mg daily for severe anxiety

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110



Th TRIAVIL® Potential in the management of moderate to severe anxiety with depression

When time and talk are not enough...
The therapist is the primary catalyst for change in the psychotherapeutic relationship. However, when patients suffer from moderate to severe anxiety with depression, there are situations when TRIAVIL can often be a useful adjunct.

...TRIAVIL may help
There are three important benefits you may expect when TRIAVIL is part of the treatment program: (1) When symptoms of moderate to severe anxiety or agitation with depression are relieved, the patient may become more accessible and cooperative. (2) As somatic manifestations are controlled, attention may be focused on underlying causative factors. (3) Symptomatic relief may enable the patient to function more effectively in his daily life while your work with the patient progresses.

Since it is simpler to remember to take one tablet rather than several (particularly in multiple daily doses), your patients on TRIAVIL will be more likely to take proper doses of the medication. And, of course, economy is an added factor in therapy with TRIAVIL.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Suicide is inherent in any depressive illness so patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please turn to the following page.

when patients exhibit moderate to marked anxiety or agitation with symptoms of depression

TRIAVIL® (containing perphenazine and amitriptyline HCl)

an antidepressant tranquilizer

when patients exhibit moderate to marked anxiety
or agitation with symptoms of depression



TRIAVIL® 4-25

Each tablet contains
4 mg. perphenazine and
25 mg. amitriptyline HCl

a formulation particularly suited to psychiatric practice
when higher doses are required.

Also Available:
TRIAVIL® 2-25: Each tablet contains
2 mg. perphenazine and 25 mg. amitriptyline HCl.

TRIAVIL® 2-10: Each tablet contains
2 mg. perphenazine and 10 mg. amitriptyline HCl.

TRIAVIL® 4-10: Each tablet contains
4 mg. perphenazine and 10 mg. amitriptyline HCl.

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, narcotics, analgesics, antihistamines) and alcohol; bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased ocular pressure, or convulsive disorders. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.
Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction.
A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.
If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine.
Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.
Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.
Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.
Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.
Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential.
Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyper-reflexia, dystonia, akathisia, dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and EKG abnormalities (quinidine-like effect); reactivation of psychotic

processes; catatonic-like states; autonomic reactions, such as dryness of the mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitivity; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: The intravenous administration of 1-3 mg of physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

MSD
MERCK SHARP & DOHME

Addendum

A suggested four-point rating scale to help evaluate patient progress week-to-week or month-to-month when presenting symptoms include anxiety or agitation with depression.

Mood—degree of depression (facial expression, voice quality, conversation content).

1. Continued profound depression, feelings of hopelessness.
2. Feeling "blue," chronic pessimism, rare cheerfulness.
3. Appropriate cheerfulness, slight depression, diluted pleasure capacity.
4. Appropriate cheerfulness and optimism.

Psychomotor Activity—reflective of emotional pressure (hypoactive patient).

1. Immobile, not fulfilling daily responsibilities.
2. Generalized slowness, constant fatigue.
3. Appropriate motor activity in most instances.
4. Activity appropriate in degree and duration to environmental stimuli.

Performance—vocational.

1. Unable to perform at all.
2. Works intermittently with difficulty.
3. Full-time employment, moderate pride in achievements.
4. Full-time employment, functioning efficiently, deriving pleasure from achievements.

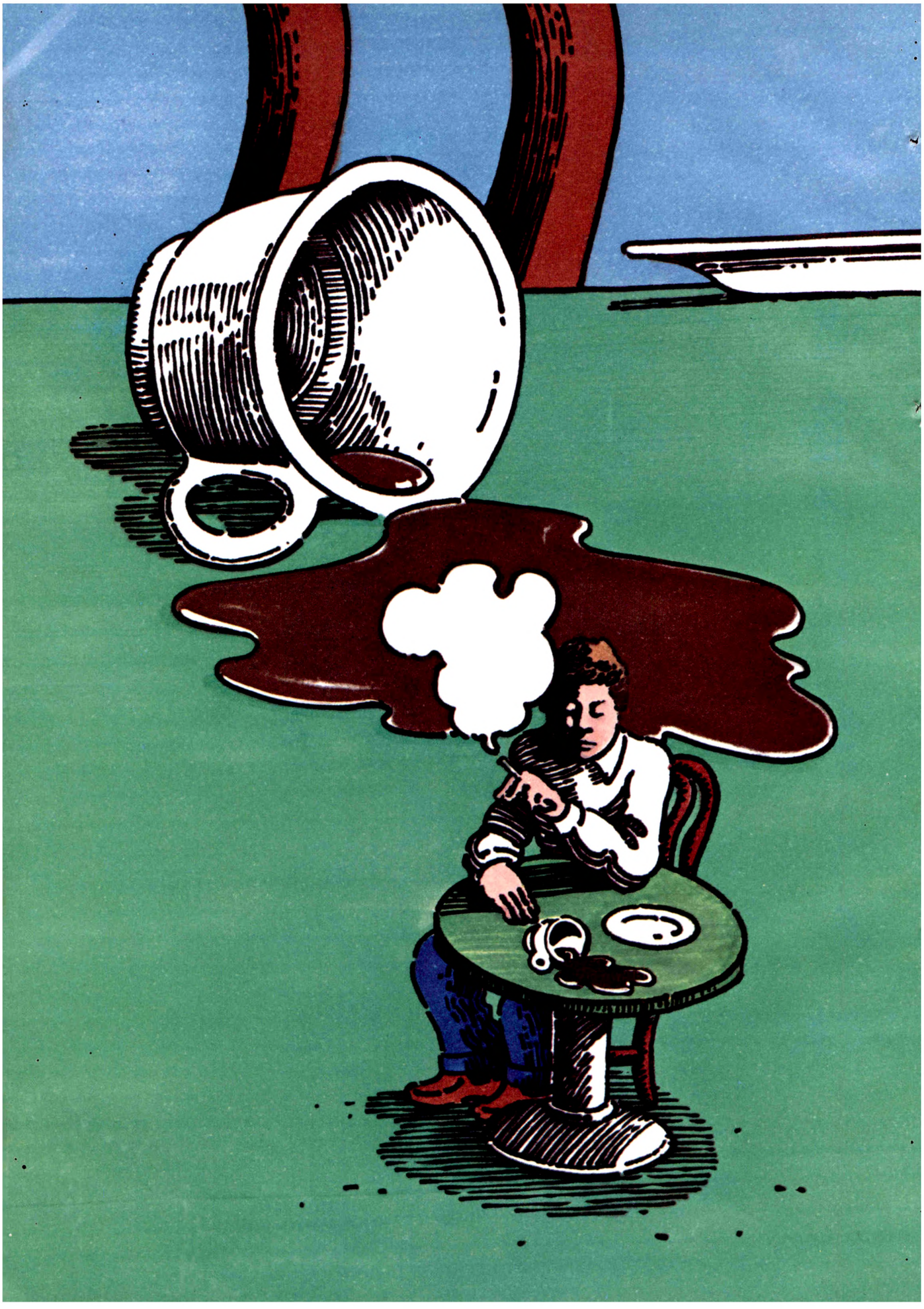
Anxiety Amelioration—in terms of motor, affective, autonomic and verbal phenomenon.

1. Panic, incessant movement, state of terror.
2. Moderate restlessness, pacing, moderate expression of fear.
3. Slight restlessness, slight affective expression of fear.
4. Calm, no restlessness, expression of fear (when it occurs) appropriate to severity of stress.

Amelioration of Symptoms

1. Symptoms unchanged or worse.
2. Fair, slight improvement, patient still plagued with symptoms.
3. Symptoms markedly reduced in intensity and frequency, able to cope.
4. All presenting symptoms gone.

Adapted from Lesse, S.: Anxiety, Its Components, Development and Treatment, Grune & Stratton, New York, 1970.



HELP GET HIM ON HIS PERSPECTIVE ON REALITY

With effective management of psychotic symptoms

- Decreases delusions, auditory and visual hallucinations
- Lessens unusual thought content, paranoid ideation
- Allays underlying fear, anxiety and tension
- Controls hostility
- Calms hyperactive behavior
- Reduces emotional withdrawal

Before prescribing, see complete prescribing information including dosage and symptoms and treatment of overdosage, in SK&F literature or *PDR*.

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders. For control of the manifestations of manic-depressive illness (manic phase).

Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

©1967, 1968, 1969 SmithKline Corporation

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudoparkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema. NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Supplied: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg., in bottles of 100; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg., in bottles of 50; Injection, 25 mg./ml.; Syrup, 10 mg./5 ml.; Suppositories, 25 mg. and 100 mg.; Concentrate, 30 mg./ml. and 100 mg./ml.

Smith Kline & French Laboratories
Division of SmithKline Corporation
Philadelphia, Pa. 19101

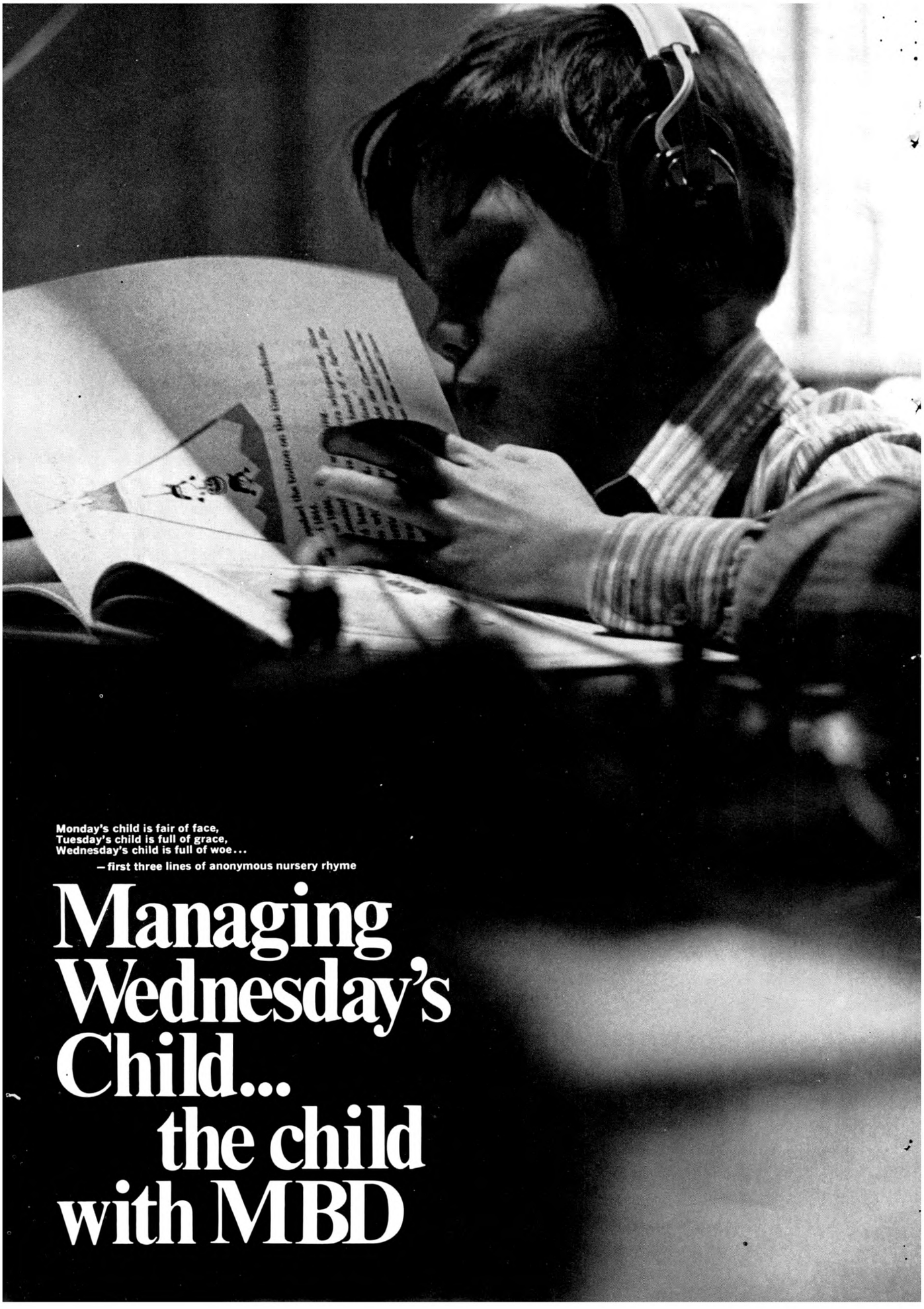
SK&F

THORAZINE®

brand of

CHLORPROMAZINE

Tablets:
50 mg. of the HCl



Monday's child is fair of face,
Tuesday's child is full of grace,
Wednesday's child is full of woe...

—first three lines of anonymous nursery rhyme

Managing Wednesday's Child... the child with MBD

"Wednesday's child is full of woe"
It need not be this way for the MBD child.
He can learn and adjust if given a helping hand.

Without help, the MBD child may be a slow reader, can find writing difficult, and arithmetic hard to grasp. He may be excitable, and his actions can be disruptive. The result can seriously hamper his educational and social development.

But, properly diagnosed and treated, MBD – Minimal Brain Dysfunction – can be brought under control so that the afflicted child can develop normally.

And Ritalin can play an important part in the total rehabilitation program of the MBD child, which includes remedial measures at home and at school. It's currently the drug of choice in many MBD situations.[1]



Ritalin is well tolerated. It can help control the excessive motor activity of the MBD child and ameliorate behavioral and learning problems.

Of course, Ritalin is not indicated for childhood personality and behavioral disorders not associated with MBD.

Reference

1. Charlton, M. H.: Paper presented at the Annual Convention of the Medical Society of the State of New York, New York, N.Y., Feb. 7, 1971.

Ritalin® hydrochloride ©
(methylphenidate hydrochloride)

TABLETS

INDICATION

Minimal Brain Dysfunction in Children—as adjunctive therapy to other remedial measures (psychological, educational, social)

Special Diagnostic Considerations

Specific etiology of Minimal Brain Dysfunction (MBD) is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources.

The characteristic signs most often observed are chronic history of short attention span, distractibility, emotional lability, impulsivity, and moderate to severe hyperactivity; specific learning disabilities; perceptual motor impairment; minor neurological signs and abnormal EEG. The diagnosis of MBD must be based upon a complete history and evaluation of the child and not solely on the presence of one or more of these signs.

Drug treatment is not indicated for all children with MBD. Appropriate educational placement is essential and psychological or social intervention may be necessary. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin is not recommended for children under six years, since safety and efficacy in this age group have not been established. Since sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available, those requiring long-term therapy should be carefully monitored. Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states. Ritalin may lower the convulsive threshold in patients with or without prior seizures; with or without prior EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued.

Use cautiously in patients with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenylhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless, in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, and erythema multiforme with histopathological findings of necrotizing vasculitis); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmias; abdominal pain; weight loss during prolonged therapy. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently. Toxic psychosis has been reported.

DOSAGE AND ADMINISTRATION

Children with Minimal Brain Dysfunction (6 years and over)

Start with small doses (eg, 5 mg before breakfast and lunch) with gradual increments of 5 to 10 mg weekly. Daily dosage above 60 mg is not recommended. If improvement is not observed after appropriate dosage adjustment over a one-month period, the drug should be discontinued.

If paradoxical aggravation of symptoms or other adverse effects occur, reduce dosage, or, if necessary, discontinue the drug.

Ritalin should be periodically discontinued to assess the child's condition. Improvement may be sustained when the drug is either temporarily or permanently discontinued.

Drug treatment should not and need not be indefinite and usually may be discontinued after puberty.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Strip Dispensers of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500, and 1000.

Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

2/4754 17

Ritalin®
(methylphenidate)
only when medication is indicated

CIBA

A45

INDEX TO ADVERTISERS

December 1973

The publication of an advertisement in this journal does not imply endorsement of the product or service by the American Psychiatric Association.

ANNA MONIKA FOUNDATION A23

AYERST
Premarin A16–A18

CIBA PHARMACEUTICAL COMPANY
Ritalin A32–A33
Ritalin MBD A44–A45

DEVEREUX FOUNDATION C4

EMPLOYMENT OPPORTUNITIES A19

KNOLL PHARMACEUTICAL
Akineton A27

LAKESIDE LABORATORIES
Norpramin A50–C3

LEDERLE
Stresstabs A47

McNEIL LABORATORIES, INC.
Haldol A9–A10

MERCK SHARP & DOHME
Cogentin A48–A49
Elavil A20–A22
Triavil A38–A41
Vivactil A30–A31

PFIZER INC.
Sinequan A35

REUBEN REITER, ScD. INC.
Electrostimulators A11

ROCHE LABORATORIES
Librium A36–A37

SANDOZ
Mellaril A24–A26

SANITARIUMS AND PRIVATE HOSPITALS A34

SMITH KLINE AND FRENCH LABORATORIES
Stelazine C2
Thorazine A42–A43

SQUIBB HOSPITAL DIVISION
Prolixin Decanoate A6–A8

U.S.V. PHARMACEUTICAL CORP.
Chlor-PZ A15
Pertofrane A28–A29

WYETH LABORATORIES
Serax A12–A14

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Act of October 23, 1962; Section 4639, Title 39, United States Code)

1. Date of filing: October 1, 1973.

2. Title of publication: THE AMERICAN JOURNAL OF PSYCHIATRY.

3. Frequency of issue: monthly.

4. Location of known office of publication: 69 Lyme Road, Hanover, N. H. 03755.

5. Location of the headquarters or general business offices of the publishers: 1700 Eighteenth St., N.W., Washington, D.C. 20009.

6. Names and addresses of publisher, editor, and managing editor: American Psychiatric Association, address 1700 18th St., N.W., Washington, D.C. 20009; Editor: Francis J. Braceland, M.D., above address; Managing Editor: Evelyn S. Myers, above address.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given): American Psychiatric Association, 1700 Eighteenth St., N.W., Washington, D.C. 20009.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purpose have not changed during the preceding 12 months.

10. Extent and nature of circulation: Average no. copies each issue during preceding 12 months: A. Total no. copies printed (net press run): 27,424; B. Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales: None; 2. Mail subscriptions: 26,163; C. Total paid circulation: 26,163; D. Free distribution (including samples) by mail, carrier or other means: 274; E. Total distribution (Sum of C and D): 26,437; F. Office use, left-over, unaccounted, spoiled after printing: 987; G. Total Sum of E & F—should equal net press run shown in A): 27,424.

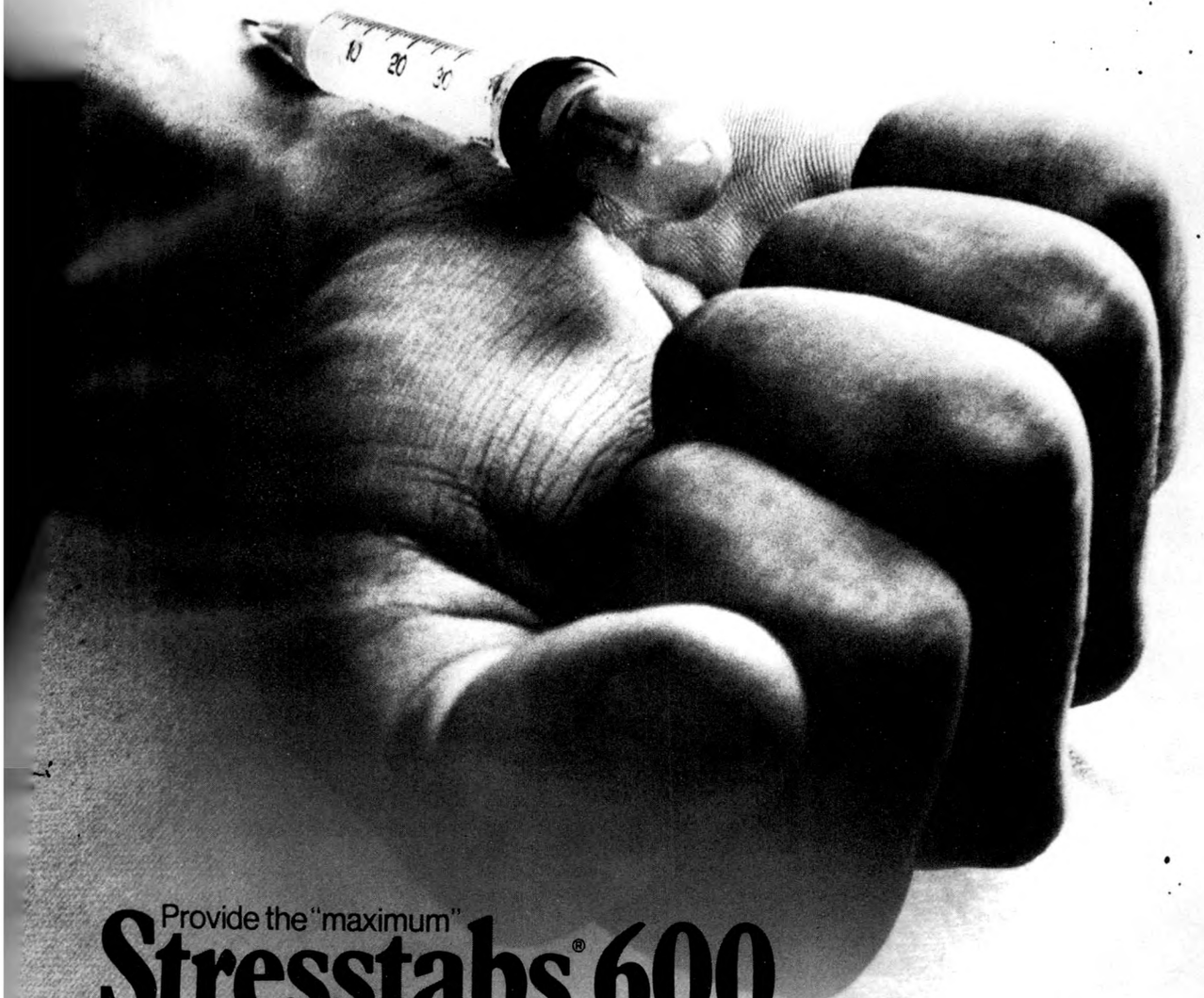
Actual number of copies of single issue published nearest to filing date: A. Total no. copies printed (net press run): 27,638; B. Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales: None; 2. Mail subscriptions: 26,343; C. Total paid circulation: 26,343; D. Free distribution (including samples) by mail, carrier or other means: 295; E. Total distribution (Sum of C and D); 26,638; F. Office use, left-over, unaccounted, spoiled after printing: 1,000; G. Total (Sum of E & F—should equal net press run shown in A): 27,638.

I certify that the statements made by me above are correct and complete.

(Signature of editor, publisher, business manager, or owner)

ROBERT J. LOWE

Drugs can give him a vitamin low.



Provide the "maximum"

Stresstabs® 600

High Potency Stress Formula Vitamins

Each Tablet Contains:

Vitamin B_1 (as Thiamine Mononitrate)	15 mg (15 MDR)
Vitamin B_2 (Riboflavin)	15 mg (12½ MDR)
Vitamin B_6 (Pyridoxine Hydrochloride)	5 mg
Vitamin B_{12} (as present in concentrated extractives from streptomyces fermentation)	5 mcgm
Vitamin C (as Sodium Ascorbate and Niacinamide Ascorbate)	600 mg (20 MDR)
Niacinamide (as Niacinamide Ascorbate)	100 mg (10 MDR)
Vitamin E (as *d*-Alpha Tocopheryl Acid Succinate)	30 Units
Calcium Pantothenate USP	20 mg

MDR—Adult Minimum Daily Requirement. Recommended Intake: Adults, 1 tablet daily or as directed by physician. Supplied: Bottles of 60 and 500.

Lederle LEDERLE LABORATORIES, Division of American Cyanamid Company, Pearl River, New York 10965 732-3

patients most in need of phenothiazines are often least able to cope with their side effects



TABLETS: 0.5 mg, 1 mg, and 2 mg
INJECTION: 1.0 mg/ml

COGENTIN®

(Benztropine Mesylate | MSD)

added to the regimen helps alleviate phenothiazine-induced extrapyramidal symptoms

In a recent study of 71 patients treated with antipsychotics, COGENTIN, administered in a double-blind manner in various dosage schedules, was found to be highly successful in relieving phenothiazine-induced extrapyramidal symptoms.[1] Patients experienced relief of such symptoms as facial and hand tremors, muscle weakness, sensations of psychic and motor excitation, and akathisia.

1. Neu C, Dimascio A, Demirgian E: Antiparkinson medication in the treatment of extrapyramidal side effects: single or multiple daily doses? Curr Ther Res *14*:246, May 1972.

Contraindications: Children under three years of age; use cautiously in older children.

Warnings: Safe use in pregnancy not established. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle.

Precautions: Because of cumulative action, continued supervision is advisable. Closely observe patients with tendencies to tachycardia or hypotension and those with prostatic hypertrophy. Dysuria may occur, but rarely becomes a problem. Large doses may cause complaints of weakness and inability to move particular muscle groups, requiring dosage adjustment.

Mental confusion and excitement may occur with large doses, or in susceptible patients; visual hallucinations reported occasionally. May intensify mental symptoms when used to treat extrapyramidal disorders due to CNS drugs, such as reserpine and phenothiazines, in patients with mental disorders; in such patients, increased doses of antiparkinsonian drugs can precipitate toxic psychosis; observe patients carefully, especially at the beginning of treatment or if dosage is increased. Masking action on possible development of permanent extrapyramidal symptoms with prolonged phenothiazine therapy has not been investigated. Patients with a poor mental outlook are usually poor candidates for therapy.

May produce anhidrosis; give with caution during hot weather, especially to the old, the chronically ill, the alcoholic, those who have central nervous system disease, those who do manual labor in a hot environment, and those with disturbances in sweating. If anhidrosis appears, reduce dosage so that ability to maintain body heat equilibrium is not impaired. Occurrence of glaucoma is a possibility; probably should not be used in angle-closure glaucoma.

Large doses generally cannot be tolerated by older patients, thin patients, or patients with arteriosclerotic parkinsonism. Do not terminate other antiparkinsonism agents abruptly; reduce gradually. In drug-induced parkinsonism, closely observe patients for severe reactions, and temporarily discontinue COGENTIN (Benztropine Mesylate, MSD) if they appear; do not extend therapy longer than necessary to counteract the extrapyramidal disorders; although the psychotropic drug frequently can be continued without change of dosage, a decrease might be indicated.

Adverse Reactions: Adverse reactions may be anticholinergic and/or antihistaminic. Dry mouth, blurred vision, nausea, nervousness may develop. If dry mouth causes difficulty in swallowing or speaking, or loss of appetite and weight, reduce dosage, or discontinue drug temporarily. Vomiting occurs infrequently and may be controlled by temporary discontinuation, followed by resumption at a lower dosage. Constipation, numbness of the fingers, listlessness, and depression may develop. Occasionally, an allergic reaction, e.g., skin rash, develops; sometimes this can be controlled by reducing dosage, but occasionally requires discontinuation.

Supplied: Tablets in three strengths: 0.5 mg and 1 mg benztropine mesylate, in bottles of 100, and 2 mg benztropine mesylate, in bottles of 100 and 1000. Injection, containing 1.0 mg benztropine mesylate and 9.0 mg sodium chloride per ml, in 2-ml ampuls.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

Facts about dosage schedules of COGENTIN (Benztropine Mesylate | MSD) in treating drug-induced extrapyramidal symptoms

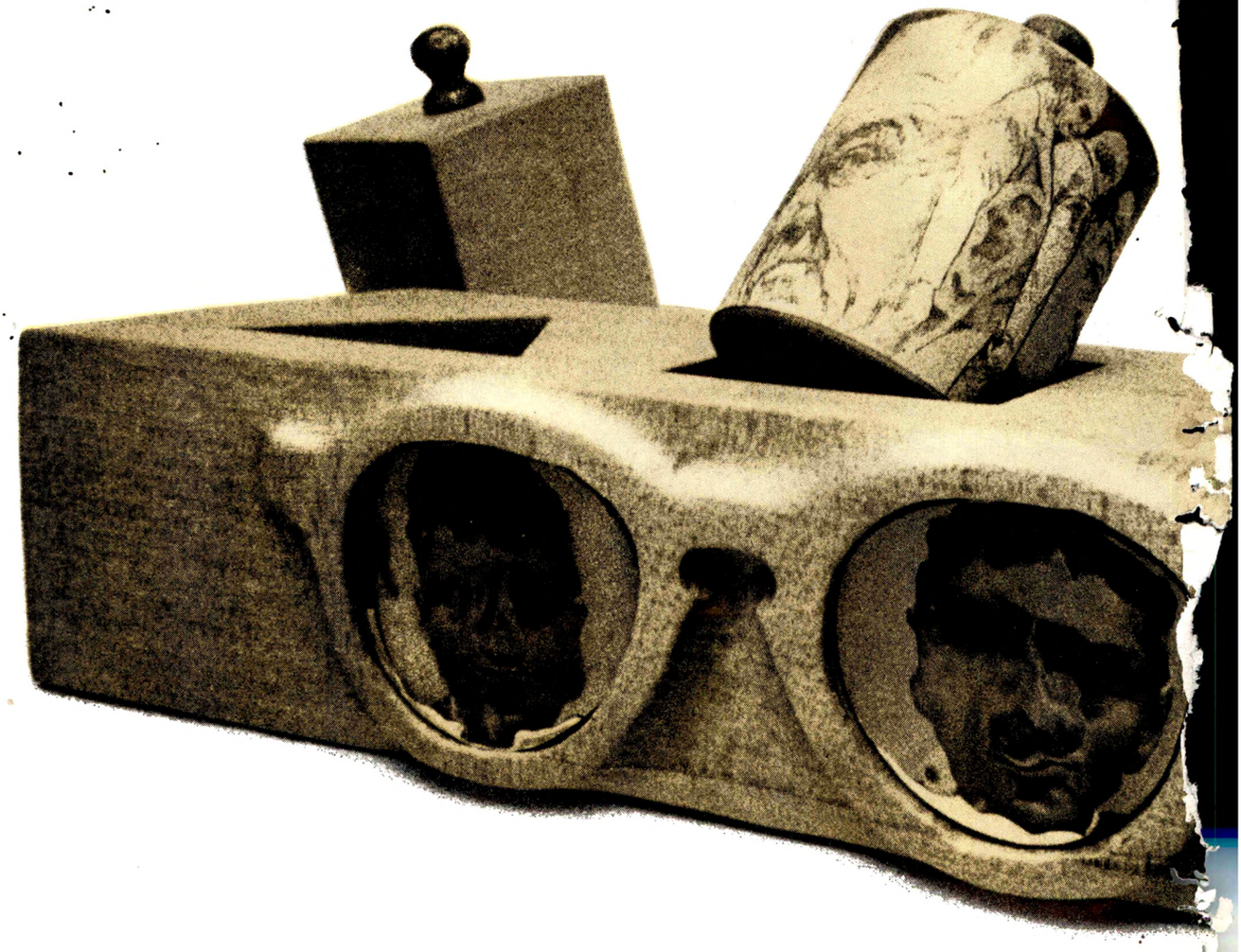
In treating extrapyramidal symptoms due to central nervous system drugs, such as reserpine and phenothiazines, the recommended dosage of COGENTIN is 1 to 4 mg once or twice a day orally or parenterally. The tablet form should be used when patients are able to take oral medication.

When extrapyramidal symptoms develop soon after initiation of phenothiazine treatment, they are likely to be transient. One to 2 mg COGENTIN orally two or three times a day usually provides relief within one or two days. After one or two weeks, COGENTIN should be withdrawn to determine the continued need for it. If symptoms recur, COGENTIN can be reinstituted.

Extrapyramidal symptoms that develop slowly usually are less responsive. They may require more prolonged treatment with 2 to 6 mg a day.

For more detailed information, see full prescribing information.

Help improve your depressed patients' ability to cope.



In Brief:

Actions: Norpramin® (desipramine hydrochloride) is an antidepressant drug of the tricyclic type. It has been found in some studies to have a more rapid onset of action than imipramine; antidepressant efficacy is similar though potency on a weight basis may be less. The earliest manifestations consist mainly of an increase in psychomotor activity. Full treatment benefit is seldom attained before the end of the second week.

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of psychosis in schizophrenic patients. Close supervision and careful adjustment of dosage are required when this drug is given along with anticholinergic or sympathomimetic drugs. While taking this drug, response to alcoholic beverages may be exaggerated. There is limited clinical experience in the concurrent administration of ECT and antidepressant drugs; thus, one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especial



Coping with Depression

The ability to cope with depressive illness, for the patient and to some degree for the physician, largely depends on hope—a crutch that is usually lacking in the depressed patient. To the depressed patient all the good things of life are bleak, black, or unattainable; all that is bad has been happening or will happen. Helping such a patient to cope with life again, to overcome the incapacitating moods, outlooks, and fears which characterize depression, can be a most rewarding experience for the physician.

Although Norpramin® (desipramine hydrochloride) is relatively rapid-acting, the patient should be told that he will not feel better immediately but that he will gradually become his old self again. A minor tranquilizer in appropriate dosage may be used with Norpramin temporarily if anxiety due to depression is present; a phenothiazine may be used similarly if agitation is severe.

Frequently, Norpramin and your own understanding of the patient are all that is necessary.

Norpramin®
(desipramine hydrochloride)
helps the depressed cope with life again.

in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary frequency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

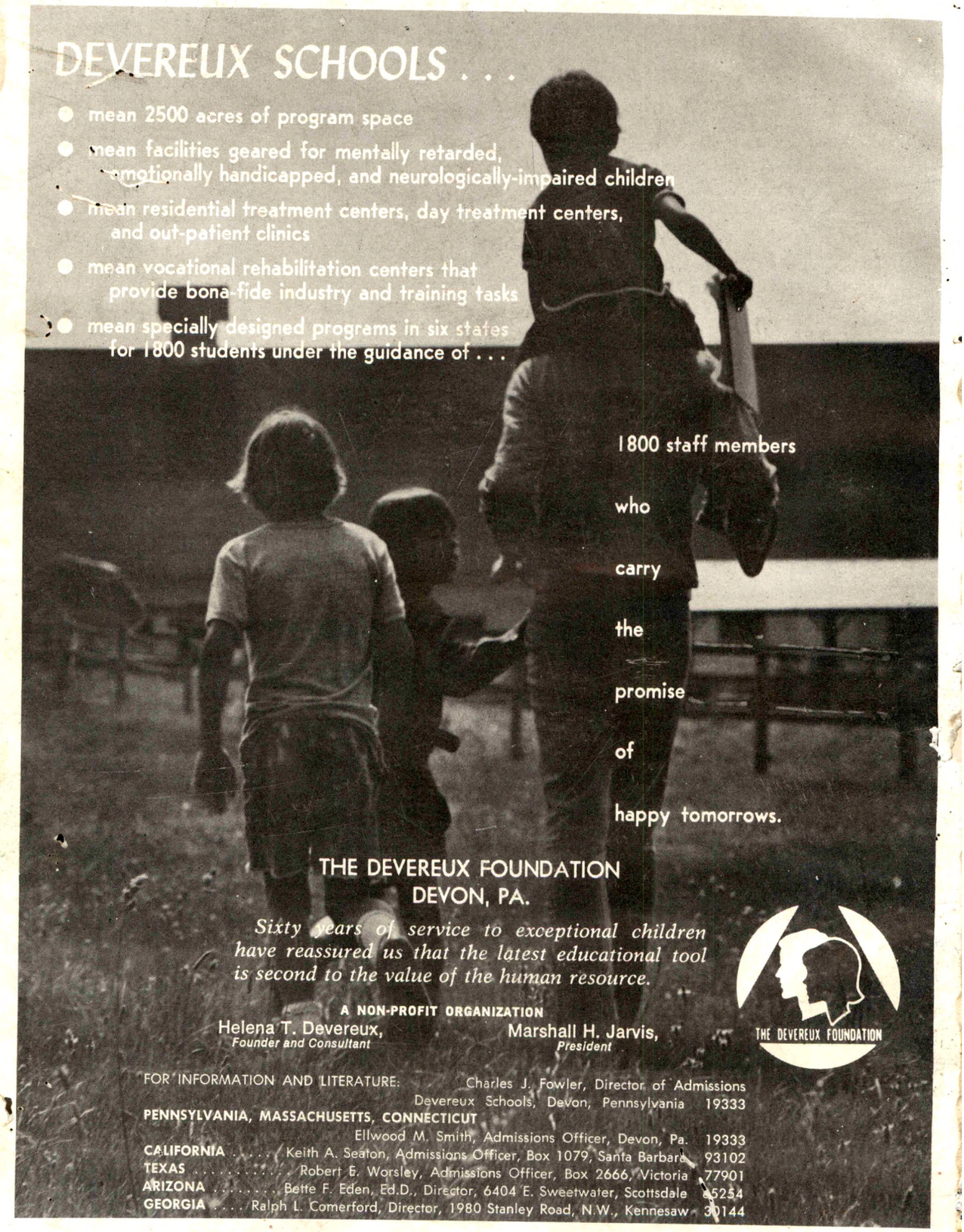
Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

How Supplied: Norpramin® (desipramine hydrochloride) *25 mg.,* sugar coated tablets, yellow, in bottles of 50, 500 and 1000 tablets. Norpramin® (desipramine hydrochloride) *50 mg.,* sugar coated tablets, light green, in bottles of 50. 250 and 1000 tablets.

Manufactured by LAKESIDE LABORATORIES
Division of Colgate-Palmolive Company

Distributed by
LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201


DEVEREUX SCHOOLS . . .
● mean 2500 acres of program space
● mean facilities geared for mentally retarded, emotionally handicapped, and neurologically-impaired children
● mean residential treatment centers, day treatment centers, and out-patient clinics
● mean vocational rehabilitation centers that provide bona-fide industry and training tasks
● mean specially designed programs in six states for 1800 students under the guidance of . . .
1800 staff members who carry the promise of happy tomorrows.
THE DEVEREUX FOUNDATION
DEVON, PA.
Sixty years of service to exceptional children have reassured us that the latest educational tool is second to the value of the human resource.
A NON-PROFIT ORGANIZATION
Helena T. Devereux, Founder and Consultant
Marshall H. Jarvis, President
THE DEVEREUX FOUNDATION
FOR INFORMATION AND LITERATURE:
Charles J. Fowler, Director of Admissions
Devereux Schools, Devon, Pennsylvania 19333
PENNSYLVANIA, MASSACHUSETTS, CONNECTICUT
Ellwood M. Smith, Admissions Officer, Devon, Pa. 19333
CALIFORNIA . . . . . Keith A. Seaton, Admissions Officer, Box 1079, Santa Barbara 93102
TEXAS . . . . . Robert E. Worsley, Admissions Officer, Box 2666, Victoria 77901
ARIZONA . . . . . Bette F. Eden, Ed.D., Director, 6404 E. Sweetwater, Scottsdale 85254
GEORGIA . . . . Ralph L. Comerford, Director, 1980 Stanley Road, N.W., Kennesaw 30144